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bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat. Clin. North America*: **4**:1079 (Nov.) 1957. (8) Livingston, S., & Pauli, L.: *Pediatrics* **19**:614, 1957. (9) Carter, C. H., & Maley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton, J. G.: *Proc. Staff Meet. Mayo Clin.* **33**:105, 1958.

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Editorial

Peniwisle

From the fiercely glowing forges of the pharmaceutical industry has issued another significant contribution to the pressing needs of therapeutics.

This newest arrival on the medical scene is a combination of two well established therapeutic agents which, by their happy union, have provided a new "vistaspectrum" agent. It is further heartening to find two competitive drug firms combining their resources in the formulation of a product for the common good. These two products penipetit (Penisyn,[R] LaBelle Laboratories) and corticowhistle (Whi-cort,[R] J. P. Wort and Co.) are, of course, familiar items of the armamentarium.

Perhaps the first recognition of therapeutic properties of Penisyn should be credited to an otherwise unknown and untutored sheepherder in the mountainous Basque province of Northern Spain. This remarkably perceptive individual found that leaves of a plant indigenous to very high mountain slopes in his native province, when collected during the rutting season of the chamois, effectively improved the taste of his otherwise harsh wine. It was this lonely and often depressed guardian of the sheep who noted the remarkable changes in mood following the ingestion of large quantities of this crude extract. This important therapeutic principle would undoubtedly have been lost to medicine had it not been for the world wide activities of the American pharmaceutical industry. In 1942 agents of LaBelle Laboratories were diligently searching the world for the very finest sherry wines for use as a vehicle in which to make more palatable their vitamin products to a highly competitive and taste-concious market. One of these representatives happened across this very happy sheepherder in his most remote and desolate country and, according to the customs of the region was offered a cup of wine. He was immediately impressed by the pleasant taste that the exotic leaf imparted to the otherwise indifferent wine. As neither individual recognized the scientific potential of the leaf, the secret and an exclusive right to export of the product was purchased for the sum of one penny (and much labor). The plant was named Pennywort in deference to the purchase price and in honor of Mr. J. P. Wort, president of LaBelle.

Remarkable properties of the pennywort-wine-vitamin elixir sold under the trade name Winovit[R] became rapidly established. Another drug house, J. P. Wort and Co., was licensed to produce the combination under the trade name Vinvit[R] and eventually allowed marketing of a less potent over-the-counter product, Vitavin,[R] by a subsidiary company, Wort Brothers. These products have reached exceptionally wide use—particularly in the treatment of temperate older individuals.

Due to the limited supply of suitable pennywort leaves a great deal of effort was expended by scientists of LaBelle to extract, characterize and synthesize the active principle of pennywort leaves. This substantial achievement was accomplished over a period of about two years and the synthetic material assigned the generic name "penipetit" and the trade name "Penisyn.[R]" A wide variety of pharmaceutical forms of Penisyn were then made available including scored compressed tablets in strength of 10 mg., 25 mg. and 100 mg., delayed action tablets containing 200 mg. and 400 mg. of the active principle, pediatric and geriatric elixirs, a syrup suitable for use as a topping for ice cream, pessary shaped suppositories, a tincture for external use as well as other dosage forms.

The drug has become established as a wide spectrum psychotherapeutic agent admirably suitable for the treatment of the greater proportion of office patients. Moreover the drug exhibits anti-rheumatic effects particularly when administered with aspirin. It is effective as a diuretic when given with

copious quantities of water, as a harmless preanesthetic agent, as a weight reducer when combined with a 500 calorie diet and, strangely, a weight stimulator when administered with a 3500 calorie diet. It serves as an effective surface antiseptic when incorporated into 70% alcohol. It's soporific qualities are particularly evident when taken in a glass of warm milk immediately upon retiring. The remarkable synergistic and antagonistic properties of Penisyn are further evident with a wide variety of other medications. An interesting development occurred soon after introduction of the synthetic drug much to the initial concern of the company. It was discovered that Penisyn was being widely used as a substitute for Penicillin, undoubtedly due to the unfortunate similarity in names. On investigating the results of such usage the surprising fact became apparent that the drug was indeed effective in at least 60% of the cases in which penicillin would have been used.

Despite the unparalleled wide use of Penisyn virtually no toxicity has become apparent. However, reports have recently appeared indicating that the drug might have addicting properties in addiction-prone individuals after prolonged use.

As might be expected, even in this era of miracle drugs, Penisyn does have several short comings. While it frequently produces temporary beneficial effects in acute leukemia, disseminated lupus erythematosus, blastomycosis, cirrhosis of the liver, Addison's disease and other severely life-threatening diseases it has not proven curative of these diseases. Thus in a very happy exchange with J. P. Wort and Co. (which illustrates the remarkable cooperation between, at least certain, pharmaceutical houses) another agent was acquired to form the exciting combination which has been recently introduced.

The latter drug is a steroid of the glucocorticoid series known by the generic name of corticowhistle (Whi-Cort,[R] J. P. Wort & Co.). This agent has never reached the popular use which it deserves due to the prior introduction of a vast number of other glucocorticoids already thoroughly familiar to the physician. However it is an extremely potent anti-inflammatory agent with very little diabetogenic effect in individuals without a predisposition to diabetes, producing very little evidence of Cushing's syndrome when given for periods of less than one week and a very low incidence of symptoms characteristic of peptic ulcer.

Penipetit and corticowhistle when mixed in the dry form proved to be noninflammable, nonexplosive, nonhygroscopic, did not change color on exposure to the elements and produced no objectionable after-taste. Thus it was put on clinical trial and after exhaustive study by 10,000 physicians (of whom only 500 had the courtesy to report their results) in a wide variety of disorders was cautiously introduced on the market under the trade name of Peniwisle.[R]

Extensive advertising space is being immediately devoted to acquainting the medical profession with this product, largely devoted to the purpose that prescribers of the drug quickly learn to spell the rather difficult name. A large part of these full page presentations, attractively printed in red on a gold background, has been devoted to listing the names of the 500 physicians who pioneered the original clinical trials of the product. Therapeutic claims have not been extravagant and the theme has been simply stated "When in doubt—use Peniwisle.[R]" A simple line drawing of the serene shepherd happily fluting to his contented sheep is prominently displayed in the upper left quarter of the advertisement. A little gimmick that has been used to introduce the physician to the product is a silver flute, which can also be used as a monaural stethoscope, with the word "Peniwisle" engraved in small letters along the embouchure.—*R.W.P.*

Scientific Articles

The current status of valvular surgery and radioactive iodine therapy.

Selected Problems of Treatment in Congestive Heart Failure

WILLIAM FINIS EWING, JR., M.D.

William Finis Ewing, Jr., M.D., graduated from the University of Oklahoma School of Medicine in 1953. Doctor Ewing is now practicing in Tulsa, Oklahoma where his practice is limited to his specialty, internal medicine.

This is the fifth of a series of articles prepared for *The Journal* under the auspices of the Oklahoma Heart Association and its committee on Professional Education, emphasizing the theme of the Association for the current year. Previous related articles have touched on more conventional medical treatment of congestive failure. Doctor Ewing has selected three of the more controversial means of therapy and attempted to survey their current status. Treatment of congenital heart disease has been ignored.

Surgery in Mitral Stenosis

MITRAL VALVULAR LESIONS are the most common ones following rheumatic heart disease and of all the valvular lesions mitral stenosis has been most successfully attacked surgically so far. One of the most difficult aspects of evaluating the effect of surgical treatment of stenosis of the mitral valve is lack of knowledge of and wide variation in the course of this disease when medical management alone is used. The average age of death in people with mitral stenosis is about forty-five; 25% survive beyond fifty. A patient with the findings of mitral stenosis in his late twenties or early thirties poses a difficult prognostic problem, indeed. Certain milestones in the course of the disease portend an unfavorable prognosis; among these are atrial fibrillation, episodes of pulmonary edema, and finally right heart failure with edema. According to Wilson & Greenwood with the onset of right heart failure, 25% of the patients will be dead within six months.

Before quoting Ellis, Harken & Black in the grim matter of mortality statistics, some explanation of their classification of mitral stenosis is necessary. That classification adheres fairly closely to the New York Heart Association classification.

Class I—No symptoms.

Class II—Slight restriction in exercise tolerance because of pulmonary symptoms but no progression.

Class III—Progressive pulmonary symptoms and ordinary activity curtailed.

Class IV—Right heart failure—cardiac invalidism.

Ellis, Harkins & Black, in a review of 1,000 cases followed from one to nine years following mitral commissurotomy, had an over-all mortality of 8%. Patients in Class II and

III who made up 400 of the first 500 cases had an operative mortality of 6%. In their second 500 cases of Group II and III (375) the operative mortality was 0.8%. In Group IV (145), of the first 500 cases the mortality was 27%. In the last 500 cases reviewed of which 125 were of Group IV, the operative mortality was 19%.

Complications and morbidity related, or possibly related, to surgery consisted of a 30% incidence of the so-called "post commissurotomy syndrome." The incidence of peripheral embolization was very high in early cases; however, in the last 500 cases the over-all incidence was 3.5% with Group IV patients having much the higher rate.

If we now turn to the results of the operative procedure on the same 1,000 patients: Of Group IV patients, 100 have been followed five years and 60% are alive. This is 60% of the total number operated on and considering that 19% died at the time of operation this seems a definite improvement in longevity. Of the Group II and III patients, 400 patients have been followed five years with survival of 84% at that time (operative mortality of 6%).

Ellis and co-workers considered the patients significantly improved if in their opinion they had moved up I or II Grades in the American Heart Association Classification for heart disease. In Group II and III patients, (New York Heart Association) 83% were considered significantly improved (83% of 700 cases) at the end of one year. At the end of five years, 76% (of 400 cases) were considered improved. Again, in Group II and III at the end of eight years (29 cases) 55% were considered improved. In Group IV, after the first year, 68% (205 cases) were considered significantly improved. In both classifications, 3% were made worse. These were primarily patients in which mitral insufficiency was either made worse or induced.

Younger patients and patients with normal sinus rhythm had significantly better results than their elders and those with atrial fibrillation.

In consideration of the effect of valvulotomy, including appendage amputation and atrial flushing on embolism, let us look briefly at these figures from the same 1,000 patients: 18% had had emboli prior to operation. In the total follow-up, 2.5% have had emboli since operation at an average time of four years postoperatively (+3.5% operative emboli).

It would appear, from the above figures and considering the enthusiasm of the authors, that mitral valvulotomy is of benefit in the patient with mitral stenosis, causing decrease in symptomatology and probably prolonging life. The operative mortality of 5-6% in Group II and III patients compared to 20% in patients of Group IV indicates that patients should be operated on before they reach Group IV.

Recurrent embolism is probably an indication for valvulotomy.

In consideration of patients for operation the ideal candidate is a young person (under fifty) having progressive symptoms; having a mitral orifice of less than one square centimeter with not too much calcium in the leaflet; having no other valvular lesion and no extensive myocardial damage. Most patients do not require cardiac catheterization. A systolic murmur at the apex without any other signs of mitral insufficiency does not constitute a contraindication. Patients with associated aortic valvular disease need cardiac catheterization before a decision can be made.

Electrocardiographic evidence of LVH is a contraindication to operation for mitral stenosis. Advanced age, visible calcification, or an enlarged heart are relative contraindications.

Watt, Bigelow & Greenwood report a series of twenty-four patients who underwent mitral valvulotomy during pregnancy without mortality. They feel that patients who develop failure during pregnancy, especially episodes of pulmonary edema, should have mitral valvulotomy and that therapeutic abortion should be reserved for those who refuse mitral valvulotomy.

Radioactive Iodine Therapy

Reducing metabolic requirements to within the capabilities of the heart in an attempt

to ameliorate symptoms of congestive heart failure (and angina) is not a new idea. The obvious approach is ablation of the thyroid. In 1931 Blumgart first advocated total thyroidectomy to relieve symptoms of congestive heart failure. About 50% of his patients, he felt, got definite improvement from this method of therapy; however, operative mortality was high and the treatment was subsequently abandoned. Later, when the thiouracil group of drugs became available, these were tried. The side reactions to the drugs themselves, such as fever, rash, and the temporary nature of thyroid suppression, were drawbacks to this method of therapy. When radioactive iodine became available, Blumgart in 1948 pioneered in ablation of the thyroid with this agent. In 1955 Blumgart summarized the results of 1,000 cases treated with radioactive iodine in his and other clinics. He found that 62% of the patients with congestive heart failure had worthwhile results, and that 76% of the patients with intractable angina had worthwhile results.

In another series reported by Jaffee, of 231 patients, he found that 81% of the patients with congestive heart failure had excellent or good results. He reported an even higher figure (91%) of patients with angina who had excellent or good results. The results for patients with both congestive heart failure and angina were not appreciably different in the two series from those for congestive heart failure. Jaffee reported that 45% of his patients were dead within a period of three to four years. The exact methods of ablating the thyroid with radioactive iodine differ; however, most are similar. Initially, fairly large doses (up to 100 millicuries of radioactive iodine) were used; however, these were abandoned because of the danger of postradiation thyroiditis and a consequent transient hyperthyroid state. At the present time most clinics give radioactive iodine in doses of 6 to 10 millicuries every week or two until a total of 30 or 40 millicuries has been given. The B.M.R. and the clinical state is followed and usually at the time the patient becomes clinically hypothyroid, improvement in symptomatology, if any, is noted. If this course of radiation fails to establish hypothyroidism, a second and even a third course is given. Thereafter, patients are given thyroid in an attempt to keep the B.M.R. at about -20 or -25, in sufficient quantity to avoid the symptoms of profound hypothyroidism, while keeping the cardiac symptoms in abeyance.

Most of the patients that one would consider for this type of therapy would be those with arteriosclerotic heart disease. Patients must be fairly stable in their congestive failure picture as it takes two to four months to achieve hypothyroidism. No one claims any increase in longevity for this treatment. It is solely a symptomatic treatment. The serum cholesterol rises as myxedema is induced.

While the results obtained with this method of treatment are not uniformly good, it is not traumatic; is almost without risk to the patient and is not terribly expensive. The induced disease is easily controlled with thyroid and is worthy of consideration in patients who are fairly stable, in severe congestive failure, or those who have had severe angina for a year and are not responding to more conventional therapy.

Surgical Treatment of Aortic Stenosis

The surgical approach to acquired aortic stenosis has been disappointing. The basis of the difficulty in surgical correction is the nature of the pathologic involvement of the valve. In aortic stenosis of clearly rheumatic etiology the valve cusps are fused most heavily near the aortic wall; the entire cusps become thickened; there is usually some associated aortic insufficiency and often an associated mitral lesion; and calcification is common. In the clinically different calcific aortic stenosis, whatever its etiology, probably no valve ever becomes "tightly" stenosed without heavy calcification and often the cusps are thickened and effectively immobolized at the base. Attempting to return these valves to a functioning state has been a formidable challenge and no one feels satisfied with surgical results, thus far.

Patients with predominate aortic stenosis live longer, on the average, than patients with mitral stenosis; those with calcific aortic stenosis often live an almost normal life span. Moreover, they are apt to be symp-

tom-free for many, many years. Once patients become symptomatic with dyspnea, angina or syncope their course is uniformly and rapidly downhill. Contratto & Levine noted the occurrence of death in aortic stenosis on an average of 23 months after the onset of dyspnea and nine months after the onset of syncope. An additional problem in those of the calcific group is the question of concomitant coronary atherosclerosis and its role in symptom production.

The clinical diagnosis of aortic stenosis in the calcific group may be less accurate than a similar diagnosis of mitral stenosis. Ellis performed left heart catheterization on 60 patients with clinical "tight" aortic stenosis, measuring the gradient between left ventricle and brachial artery and blood flow by means of dye curves. He found that his clinical diagnosis coincided with the calculated valve area in 75% of the cases. The amount of aortic insufficiency is almost impossible to assess with any technique. The clinical sign most consistently denoting a small valve area was a low pulse pressure.

Abelmann, et al., report on a group of 86 patients, followed one to four years, who were operated on by Bailey with the transaortic approach. There was an operative mortailty of 17.5%. Of 71 survivors, 11 died during the first year. Of the 60 still alive, the average follow-up was 29 months and of these, 74% were better symptomatically. The figures looked at in another way —56% of those who survived operation improved. Patients in right heart failure did poorly, there being a 38% mortality and only a 25% improvement.

In the Harken series of 100 patients with calcific aortic stenosis operated on by the transaortic route, there was an operative mortality of 16%. There were 12 additional deaths within the first year after operation. Of those surviving, 25% were markedly improved; 18% were slightly or moderately improved. Of the 50 patients who had been followed more than six months, there was 86% improvement. In the last 60 patients operated on, there have been only five deaths, a mortality percentage of eight. Harken further reports 19 patients who had both mitral valvulotomy and aortic commissurotomy with a 10.5% operative mortality.

These high figures of surgical mortality are indeed formidable; however, the patients had a malignantly progressive disease. Harken points out that, of the 54 patients advised to have aortic commissurotomies who refused, 49 were dead within six months.

Given a patient with aortic stenosis, who is developing symptoms, one is faced with this problem: one can be 75% sure that symptoms are caused by a "tight" valve; if surgical intervention is carried out the patient has a 5/6 chance of surviving the operation and if he survives the operation he has approximately a 50% chance of improvement.

The first problem, that of accuracy of diagnosis, can be improved by left heart catheterization; but even then the aortic insufficiency is difficult to assess.

At this time, surgical correction of acquired aortic stenosis is to be rarely recommended.

REFERENCES

Blumgart, H. L., Riseman, J. E. F., Davis, D., and Berlin, D. D.: Therapeutic Effect of Total Ablation of Normal Thyroid on Congestive Heart Failure and Angina Pectoris. Archives Internal Medicine 52: 165, August, 1933.

Waitzkin, L.: Treatment of Angina Pectoris with Propylthiouracil; Annals of Internal Medicine 34: 1107, May, 1951.

Blumgart, H. L., Freedberg, A. S., and Kurland, C. S.: Treatment of Incapacitated Euthyroid Cardiac Patients with Radioactive Iodine. Journal of American Medical Association 157: 1, January, 1955.

Jaffee, H. L., Rosenfield, M. H., Pobirs, F. W., and Stuppy, L. J.: Radioiodine Treatment of Euthyroid Cardiac Disease 159: 434, October, 1955.

Wilson, J. K., and Greenwood, W. F.: The Natural History of Mitral Stenosis. Canadian Medical Association Journal 71: 323, 1954.

Ellis, L. B., Harken, D. E., Black, Harrison: A Clinical Study of 1,000 Consecutive Cases of Mitral Stenosis—Two to Nine Years After Mitral Valvuloplasty. Circ: 19: 803, June, 1959.

Watt, G. L., Bigelow, W. G., and Greenwood, W. F.: Six Years' Experience with Mitral Commissurotomy During Pregnancy. American Journal of Obstetrics and Gynecology 77: 505-512, March, 1959.

Abelmann, Walter H. and Ellis, L. B.: Severe Aortic Stenosis in Adults; Evaluation by Clinical and Physiologic Criteria and Results of Surgical Treatment. Annals Int. Med. 51: 449, September, 1959.

Contratto, A. W. and Levine, S. A.: Aortic Stenosis with Special Reference to Angina Pectoris and Syncope. Ann. Int. Med. 10: 1636, 1937.

Connolly, J. E.: Left Ventricular Puncture in the Assessment of Aortic Stenosis. J.A.M.A. 171: 160, September, 1959.

Litwak, R. S., Vricchio, J. F. and Likoff, W.: A Corrective Study of Valvular Morphology and Clinical Results in Aortic Commissurotomy. N. Eng. J. Med. 254: 781, 1956.

Harken, D. E., Black, H., Taylor, W. J., Thrower, W. B. and Soroff, H. S.: The Surgical Correction of Calcific Aortic Stenosis in Adults. J. of Thor. Surg. 36: 759, December, 1958.

Bailey, C. P., Bolton, H. E., Nichols, H. T., Jameson, W. L., and Litwak, R. S.: The Surgical Treatment of Aortic Stenosis. J. of Thor. Surg. 31: 375, April, 1956.

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The Treatment of Cutaneous Pyodermas

MARK ALLEN EVERETT, M.D.*

In 1951, Mark Allen Everett, M.D., graduated from the University of Oklahoma School of Medicine where he is now an Instructor in Dermatology.

Certified by the American Board of Dermatology, Doctor Everett is a member of the American Academy of Dermatology and is now serving as President of the Oklahoma State Dermatological Society. In addition, he is Consultant in Dermatology to the United States Air Force.

ANTIBIOTICS in greasy bases, either with or without the addition of cortisone derivatives, continue to be advocated for the treatment of pyodermas. Because it is the opinion of the author that an antibiotic incorporated in a non-greasy vanishing cream is the choice topical agent in the treatment of cutaneous pyodermas, the following series of cases is presented.

Methods

Seventy patients were studied. Thirty-nine received oral antibiotics. Thirty-one received only topical therapy. Three topical agents were used: Neomycin sulfate 5 mg. per gram in a special vanishing cream base:** 0.5% aqueous gentian violet; Neomycin sulfate 5 mg. per gram and Zinc bacitracin 400 units per gram in a greasy base. All cases as well as the results are summarized in Table I. All patients received instructions to bathe daily with a hexachlorophene containing soap being careful to remove all

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**Prepared and furnished by Dome Chemical Company, New York City.

TABLE I

Summary of Treatment of Pyodermas

DIAGNOSIS	Total Number	Neomycin cream	Neomycin Cream plus Antibiotic	Gentian Violet plus Antibiotic	Neomycin grease	Neomycin Grease plus Antibiotic	Antibiotic Alone
Impetigo contagiosa extensive	20	1	12	3	0	3	1
Impetigo contagiosa moderate	13	9	0	0	2	0	2
Infectious eczematoid dermatitis	6	0	4	1	0	0	1
Infected eczematoid disease of hands	11	2	1	1	3	2	2
Infected eczematoid disease of legs	3	0	1	1	1	0	0
Infected eczematoid disease in atopics	5	0	1	2	0	1	1
Infected prurigo in Indians	12	4	5	0	2	1	0
Totals	70	16	24	8	8	7	7
Time in days for complete recovery	—	5-12	3-7	4-7	8-17	8-14	6-10

crusts gently. Bathing was preceded by one hour period of soaking. Drying was accomplished by patting or fanning or both. The topical medication was then applied. All patients received an antihistamine four times daily. The antibiotic therapy utilized is summarized in the table.

Results

Of patients treated with both topical and systemic antibiotics those receiving the water miscible cream or aqueous topical agents improved more rapidly and cleared more quickly than those applying topical agents in a greasy base or those receiving no topical antibiotic. Of the milder cases treated by topical applications alone those receiving the water miscible cream or aqueous product again improved more quickly. Those patients receiving oral but not topical antibiotics responded more quickly than those receiving Neomycin in grease plus antibiotics. It was noted that in those patients treated with a greasy base small pustules and vesicles continued to form under the medication for several days. This phenomenon was not observed in the cream or aqueous group. Apparent sensitivity to gentian violet was observed in one patient. No sensitization to Neomycin was observed, confirming the low index of sensitivity reported by others.[2,3]

Comments

This study re-emphasized the superiority of water miscible and aqueous products over greases in the treatment of oozing lesions of various impetigenized diseases of the skin. Progression of the process was halted sooner and clearing was more rapid. From the view point of patient acceptability there was a marked preference for the Neomycin cream inasmuch as it was odorless, non-staining, colourless, and non-greasy. Aqueous gentian violet, while effective, met with considerable patient resistance because of the staining qualities. Contact sensitivity was not a factor in short term therapy such as carried out in this study.

Summary

Patients with various impetigenous dermatoses were treated with a topical cream containing Neomycin sulfate. Clearing of the disease process was rapid and the agent was characterized by greater patient acceptability than other agents tried.

BIBLIOGRAPHY

1. Minor, D. B., and Everett, M. D., unpublished data.
2. Sidi, E., Hinkly, M. and Lonheuville, R.: "Cross Sensitization between Neomycin and Streptomycin," J.I.D. 30: 225-231, 1958.
3. Goldbey, Lawrence C.: "Cutaneous reactions to Neomycin." Antibiotic Medicine and Clin. Ther. 4: 795-796. 1957.

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of the

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May 2, 3, 4, 1960

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MEDICAL CENTER

Cadaver Supply and the Anatomical Law

"You who investigate this our machine, let it not sadden you that you impart knowledge of it at the expense of another man's death. But rejoice that our creator has equipped the intellect to such an excellence of discernment."

These wise words of the great artist-anatomist Leonardo Da Vinci still have meaning. Even today those who are responsible for procuring human dissection material often encounter superstitions and prejudice.

The first anatomical law of the State of Oklahoma was passed by the 15th Legislature April 16, 1935. In essence, it requires that all unclaimed bodies which otherwise would be buried at public expense be turned over to the State Anatomical Board to be used for the advancement of "Medical and Anatomical Studies."

In the past this law has operated quite satisfactorily in supplying the necessary study material. But with the rise in over-all prosperity, the propagation of burial insurance and of social welfare measures providing funds for burial, and the prevalence of autopsies on mental patients and unidentified dead, a shortage of cadavers could interfere with an expanding teaching program.

The problem is, of course, nation-wide. There are already at least eight medical schools in the United States where it is no longer possible to keep up a ratio of four students per cadaver, and one school where even a ratio of eight to one cannot be maintained.

Aked in a questionnaire whether they considered their anatomical material supply was ample, representatives of almost one-third of all medical schools answered in the negative.

In Oklahoma, close liaison with superintendents of state hospitals and with responsible morticians so far has allowed us to meet our teaching requirements. The Oklahoma State Legislature has done its part to forestall an anticipated shortage. A law was passed in 1957 which can greatly alleviate the problem.

The 1957 law provides that persons who wish to donate their bodies for teaching purposes and research or parts of their bodies for therapeutic reasons can do so by simply willing them to the University of Oklahoma School of Medicine or to institutions of their choice. The law made it possible for Oklahoma Lions Clubs two years ago to establish the statewide Eye Bank at the Medical Center with the gratifying result that already more than 120 patients have been able to undergo corneal transplant operations. It also provides a source of material for bone and artery and other tissue banks that permit surgical advances in the area of tissue transplantation.

Donors have only to sign a document which is written in understandable, non-legal terms, in the presence of two witnesses. Physicians in the State of Oklahoma, who are of course best qualified to evaluate the importance of sufficient dissection material, can greatly assist in securing cadavers by informing patients of this means of contributing to the progress of medical science.

Mark R Everett

This review on the subject Cardiac Arrest was prepared for presentation at a postgraduate session of the American College of Surgeons meeting at Atlantic City, October 1959.

CARDIAC ARREST

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FEW TOPICS merit more frequent review than cardiac arrest. The occurrence of sudden cessation of circulation in a patient in whom it is not expected is a catastrophe which demands prompt and proper resuscitative efforts to prevent death or serious neurological injury. This catastrophe is increasing in frequency, and probably occurs between 8 and 9,000 times each year in the United States.

Investigation into the cause of circulatory arrest—and this includes ventricular fibrillation as well as cardiac standstill—reveals that, with the exception of ventricular fibrillation following electric shock, every instance of cardiac arrest appears to be due to a combination of circumstances. Some of these causes are understood and many are not. Among the agents recognized as contributing to cardiac arrest should be listed: hypoxia, hypercapnia, acidosis, vagal reflexes, and depressant drugs.

Anoxia or hypoxia has been considered by many surgeons as the most important cause of cardiac arrest. Hypoxia does not consistently result in sudden circulatory arrest in the laboratory animal, and, fortunately, cardiac arrest usually does not follow its clinical appearance. Although the association of hypoxia and circulatory arrest has been emphasized by Gerbode,[7] Johnson, and Kirby[8] its exact role as an etiologic agent is not clear. Emphasis on the prevention, recognition, and correction of hypoxia is certainly justified.

Hypercapnia, the accumulation of carbon dioxide in the body, may occur even in the presence of adequate oxygenation. Hypercapnia results in respiratory acidosis and hyperkalemia, and in its presence vagal inhibition of the heart is potentiated.[22] There is little doubt that this may contribute to circulatory arrest in some cases. It follows that hypercapnia, and especially sudden changes in CO_2 level, should be avoided.

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The importance of a vagal or vago-vagal reflex in causing cardiac arrest is often discussed but remains unsettled. Stimulation of the central end of the vagus nerve will cause ventricular standstill in the experimental animal, but even with continued stimulation vagal escape occurs. There are apparently no vagal fibers of the ventricles of the human heart. Reid, Stephenson, and others conclude the vagal stimulation will not cause cardiac arrest in the normal healthy heart.[14,16] In the presence of myocardial disease or temporary myocardial depression by drugs, vagal inhibition of the heart may be of great importance.

Admitting that knowledge of the etiology of cardiac arrest is incomplete, it becomes important to recognize those situations in which it is likely to occur. The majority of instances of circulatory arrest are encountered in the operating room and at the present time occur once in approximately every 1,500 operative procedures.[4,7,17,18] It does not seem coincidental that the first recognized case of cardiac arrest was reported within a few months of the introduction of anesthesia.[2] Anesthetic procedures offer the hazard of vagal stimulation during intubation and extubation, the possibility of hypoxia and hypercapnia, and the depressant effect of anesthetic agents themselves. Beecher has pointed out the apparent increase in incidence of cardiac arrest when using multiple anesthetic agents, particularly including curare like drugs.[3]

Circulatory arrest during operation is more likely to occur when no pre-anesthetic medication is given, in overly apprehensive patients, in children, and in patients with pre-existing heart disease. Furthermore, arrest has been reported most frequently during biliary and pulmonary operations.[16] An increase in frequency during cardiac operations is not surprising.

Outside the operating room, cardiac arrest is well known in the recovery room, emergency room, endoscopy clinic, and radiology department, and its occurrence in any of these areas is associated with a poor prognosis.

Recognition of cardiac arrest is simple but deserves emphasis because of its urgency. Absence of pulsation in major arteries is all that is necessary to establish the diagnosis. Beck and others have repeatedly stated that more elaborate determinations only delay resuscitation.[1] Recently, monitoring of the pulse during operation has been advocated, and it seems likely that some simple monitor with a warning system will come into common if not routine use in the future.

Successful management of cardiac arrest requires perfusion of the tissue with oxygenated blood within four minutes of cessation of circulation. The initial problem is restoration of an airway and adequate ventilation. This can be done by mouth-to-mouth breathing, as recently advocated by Elam and Benson,[6] by mask breathing using an anesthesia machine, or preferably by endotracheal intubation. When good efforts to restore ventilation are begun, the managing physician should begin circulatory restoration by cardiac massage through the open chest. If operating in the abdomen, preliminary massage can be carried out through the intact diaphragm while the chest is being opened. It is important to emphasize to untrained persons how easily the heart itself may be cut in a too rapid thoracotomy. Massage is facilitated by opening the pericardium. The position of the surgeon during massage and the method of holding the heart are matters of individual preference. The possibility of myocardial injury or actual rupture from too vigorous massage should be mentioned. The initial rate of massage is 70 to 100 per minute, and the criteria of successful manual systole is the detection of a palpable peripheral pulse. Once massage is begun the requirements of the tissues for oxygen can be met and the problem becomes one of restoring a heart beat. After myocardial tone is regained, heart beat will usually begin spontaneously. Drugs are useful when myocardial tone does not respond to massage or when ineffective beat is initiated.

The appearance of ventricular fibrillation during cardiac resuscitation is common and not necessarily ominous. Defibrillation using an electric shock should be attempted after massage has restored good tone and color to the myocardium. If the usual single shock

at 120 volts (1.5-2 amp.) is ineffective, multiple shock and higher voltage should be used after intervening periods of massage. The value of high voltages, particularly in large hearts, has not been generally appreciated.

Several drugs may be helpful in cardiac resuscitation. Epinephrine is used to improve myocardial tone and conduction. It is injected directly into any accessible chamber of the heart. The use of epinephrine is not contraindicated in ventricular fibrillation. Calcium, as emphasized by Doctor Blalock, increases myocardial contractility, but may be contraindicated in patients who have received digitalis.[10]

Circulatory arrest is always accompanied by metabolic acidosis. As Campbell has pointed out, acidosis diminishes response of the heart to presser amines.[5] For this and other reasons, sodium bicarbonate should be injected intravenously in each case of cardiac arrest.

Isuprel may have a place in the treatment of intractable ventricular fibrillation.[13] Potassium, barium, procaine, and heparin have been advocated but at the present time their value is uncertain.

Other stimulant drugs appear to have little place in the treatment of cardiac arrest.

During cardiac resuscitation, several adjuvant procedures are useful.

The patient should be placed in the Trendelenberg position to aid in perfusing the central nervous system, as well as to aid venous return to the heart.

Compression of the thoracic aorta may be advantageous in increasing flow to the brain. This occlusion should be relieved at 15 minute intervals to avoid spinal cord injury.

The influence of coronary perfusion on cardiac arythmia is very impressive during procedures involving cardio-pulmonary bypass. Some form of aortic perfusion should be considered in the unusual instances in which it is feasible.

Cardiac pacemakers are being widely advertised as essential hospital equipment. Electronic pacemakers are effective in treating ventricular asystole due to a conduction defect as in surgical trauma to the Bundle of His or in the Stokes-Adams syndrome due to other causes. They will not initiate effective contractions in the usual case of cardiac arrest.[15]

Defibrillation of the heart can be accomplished through the intact chest wall using the method and apparatus described by Kouwenhoven and Knickerbocker.[11] This has been particularly useful in the cardiac catheterization laboratory where ventricular fibrillation is a definite hazard and where the diagnosis can be instantly made from the oscilloscopic monitor of the electrocardiogram. Closed chest defibrillation of the heart has also been successful after myocardial infraction and represents a real advance in the treatment of this form of cardiac arrest.

Recently, unpublished work by Kouwenhoven and Knickerbocker has shown that in the dog compression of the closed chest is effective in restoring circulation and arterial pressure up to 90 mm. hg. can be obtained.[12] This procedure was investigated as a possibility in lengthening the period of effectiveness of closed chest defibrillation but has clinical possibilities of its own. Doctor James Jude of the Johns Hopkins Hospital has now successfully restored heart beat in three patients with asystole using external compression of the chest.[9] This procedure cannot yet be placed in our permanent armamentarium, but it may find important uses in the future.

When the heart does not respond to resuscitative efforts, there is a difficult decision as to when to discontinue resuscitation. There can be no fixed rule in this regard, but it should be mentioned that recovery has followed periods of massage exceeding four hours. The length of time between arrest and massage and the presence of persistently dilated pupils are important factors in the decision to abandon resuscitation.

The over-all prognosis for permanent survival in cardiac arrest is exceedingly difficult to estimate, but the figure given by Stephenson is 29 per cent. There is no doubt that rapid recognition and prompt treatment will result in a high survival rate. In

most institutions considerable improvement in the present rate can be achieved.

The major cause of death after successful restoration of heart beat is injury to the central nervous system. The clinical picture is that of unconsciousness and progressive decerebrate rigidity ending either in death within hours or survival with neurologic damage. Very occasionally recovery follows definite evidence of brain injury. It has been suggested that death is caused by brain swelling, which occurs in response to the original anoxic injury. If this is true, prevention of brain swelling might allow survival in cases when the original injury is not too severe. A series from the Johns Hopkins Hospital has been reported in which patients with evidence of central nervous system injury after cardiac arrest were treated by inducing hypothermia with impressive results.[19,20] Spencer and Zimmerman have shown an increase in survival rate in animals subjected to hypothermia after circulatory arrest,[24] and unpublished data from the University of Oklahoma indicates that the brain does swell following circulatory arrest.[21] Work on the use of Urea after cardiac arrest has recently been presented by Javid at the Congress of the American College of Surgeons.[23] At the present time, the induction of moderate hypothermia, or the use of Urea, seems justified in patients who show evidence of central nervous system injury after cardiac resuscitation.

A final word on the role of the surgeon in the problem of cardiac arrest. The surgeon logically has the greatest experience and interest in this catastrophe, and it is urged that he assume a hospital wide responsibility for efforts to prevent, recognize, and treat cardiac arrest. Someone must emphasize the continued necessity for proper evaluation of pre-operative patients, the value of pre-operative medication, and the need for special anesthetic care and perhaps monitoring during some procedures. Someone must see that the equipment for resuscitation is available to remote areas. Most important, all physicians must be taught the principles of resuscitation and necessity for applying them promptly. The value of animal demonstrations cannot be over estimated. The salvage of 8,000 lives a year depends upon our efforts.

BIBLIOGRAPHY

1. Beck, C. S.: "Resuscitation in Cardiac Arrest," S. Clinic North America, 247-248, 1956.

2. Beecher, H. K.: "The First Anesthetic Death With Some Remarks Suggested by it on the Fields of the Laboratory and Clinic in the Appraisal of the New Anesthetic Agents," Anesthesiology, 2: 443-449, 1941.

3. Beecher, H. K., and Todd, D. P.: "A Study of the Deaths Associated with Anesthesia and Surgery," Annals Surg., 140: 2-35, 1954.

4. Briggs, D. D., Sheldon, D. B., and Beecher, H. K.: "Cardiac Arrest: Study of a Thirty-Year Period of Operating," JAMA, 160: 17, 1956.

5. Campbell, G. S.: "Cardiac Arrest: Further Studies on the Effect of pH Changes on Vagal Inhibition of the Heart," Surg., 38: 615-634, 1955.

6. Elam, J. O., and Benson, D. W.: Personal Communication.

7. Gerbode, F., Lee, R. H., and Herrod, C. E.: "Cardiac Arrest During Surgery," S. Clinic North America, 34: 1289-1298, 1954.

8. Johnson, J., and Kirby, C. K.: "Surgery of the Chest," Year Book, 1958.

9. Jude, J. R.: Personal Communication.

10. Kay, J. H., and Blalock, A.: "The Use of Calcium Chloride in the Treatment of Cardiac Arrest in Patients," SG&O, 93: 97-102, 1951.

11. Kouwenhoven, W. B., Milner, W. R., Knickerbocker, G. G. and Chesnut, W. R.: "Closed Chest Defibrillation of the Heart," Surg., 42: 550-561, 1957.

12. Kouwenhoven, W. B., and Knickerbocker, G. G.: Personal Communication.

13. Meldelsohn, D., Jr., MacKrell, T. N., Macdonald, D. W., Nagueira, C., Head, L. R., Jr., and Kay, E. B.: "Management of the Patient During Open Heart Surgery," Surg., 45: 949-964, 1959.

14. Reid, L. C., Stephenson, H. E., Jr., and Hinton, J. W.: "Cardiac Arrest," AMA Archives of Surg., 64: 409-420, 1952.

15. Starzl, T. E., Gaertner, R. A., and Webb, R. C.: "The Effects of Repetitive Electric Cardiac Stimulation in Dogs with Normal Hearts, Complete Heart Block, and Experimental Cardiac Arrest," Circulation, 11: 952-962.

16. Stephenson, H. E., Jr.: "Cardiac Arrest and Resuscitation," C. V. Mosby Co., St. Louis, Mo., 1958.

17. Turk, L. N., III, and Glenn, W. W. L.: "Cardiac Arrest: Results of Attempted Cardiac Resuscitation in Forty-Two Cases," New Eng. J. Med., 251: 795-803, 1954.

18. West, J. P.: "Cardiac Arrest During Anesthesia and Surgery," Annals Surg., 140:4, 623-629, 1954.

19. Williams, G. Rainey, and Spencer, F. C.: "The Clinical Use of Hypothermia Following Cardiac Arrest," Annals Surgery, 148: 462-465, 1958.

20. Williams, G. Rainey, Spencer, F. C., Benson, D. W., and Yates, A. J.: "The Use of Hypothermia Following Cardiac Arrest," Research-Anesthesia and Analgesia (in press).

21. Williams, G. Rainey, and Gunn, C. G.: Unpublished Data.

22. Young, W. G., Jr., Sealy, W. C., Harris, J., and Botwin, A.: "The Effects of Hypothermia and Hypoxia on the Response of the Heart to Vagal Stimulation," SG&O, 93: 51-55, 1951.

23. Young, W. P., and Javid, M. J.: "Study of the Use of Intravenous Urea After Simulated Cardiac Arrest," Forum of the American College of Surgeons, 1959 (in press).

24. Zimmerman, J. M., and Spencer, F. C., Benson, D. W., and Yates, A. J.: "The Influence of Hypothermia on Cerebral Injury Resulting from Circulatory Occlusion,' Surgical Forum, 1958.

A brief review of Ewing's Sarcoma and its incidence in the foot with two case reports involving the tarsal bones.

Ewing's Sarcoma of the Tarsal Bones— Two Case Reports

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ENDOTHELIOMA or Ewing's sarcoma of the bone is most commonly a disease of childhood with eighty per cent of all reported cases occurring under the age of thirty. There have been isolated cases reported in children as young as six months of age.

Ewing[1] reports that the small bones and flat bones are most often involved. Lichtenstein,[2] in his book of recent date, states that peripheral bones are most often involved. The etiology of Ewing's sarcoma to date is not clearly defined. Of the numerous reports of this disease in literature, very few have been noted in the tarsal bones.

Seventeen cases of Ewing's sarcoma are reported by Lichtenstein and Jaffe,[3] none involving the feet. Wang and Schutlz[4] reported 50 cases of Ewing's sarcoma, one being in a tarsal bone. McSwain, Bird and associates[5] reported 20 cases; none of these were in the feet. McCormack, Dockery and Ghormley,[6] in 1952, reported 80 cases of Ewing's sarcoma; one case involved the metatarsal bone. Of the 177 cases reported from the Mayo Clinic in 1950, none were reported in the small bones of the foot. Morton[7] reported 190 cases of Ewing's sarcoma in 1923; one case involved the os calcis and one a metatarsal bone. Frederick Christenson,[8] in 1925, reported 87 cases; four were in the os calcis and two in the metatarsal bone.

The above review reveals only 11 cases of primary Ewing's sarcoma involving the bones of the foot. Of these 11, five involved the os calcis, one of the talus, and four of the metatarsal bones. There is one article which refers to the location of Ewing's tumor in an unspecified tarsal bone. This report adds a case involving the talus and one of the os calcis.

The clinical course of the disease varies, of course, with the histological malignancy

and other factors involved. Some subjects succumb to a very rapid growth of the original tumor, while others have survived as long as nine or fifteen years. Mortality is very high, especially with the younger individuals. The roentgenographic appearance (onion peel) which has previously been reported, certainly is not borne out with our cases, nor has it been borne out with other writers who have referred to this disease. It is a tumor which arises in the marrow spaces of the affected bones. The typical cytological appearance is that of uniform cells with ill-defined borders, the cells having little cytoplasm. The nuclei, however, are indistinct at times and appear embedded in a very loose vacuolated cytoplasmic fabric. Most of the nuclei show scattered chromatin with the nucleus two or three times as great as the diameter of a normal lymphocyte. Marked vascularity and rosettes or pseudo rosettes, which have been described as being characteristic, certainly are not as frequent or as pathognomonic as has previously been reported. The appearance of rosettes and pseudo rosettes is altered most frequently by degeneration or necrosis of the tumor. One characteristic feature of this tumor, however, is the fact that no argyrophilic fibrils are to be found. The differential diagnosis of this disease should include metastatic carcinoma of hidden origin, neuroblastomas arising from either adrenal or sympathetic nervous system, myeloma, and lymphatic lymphoma.

Figure I. Reproduction of roentgenogram of ankle showing sclerosis and mottling on the talus.

Case Report I

D. W. is an 11 year old white male who was first seen on May 17, 1954, with the chief complaint of pain and swelling in the left ankle. He states that this condition has been present approximately three and one-half years, with intermittent pain and inability to walk at times. He had had numerous antibiotic shots and whirlpool treatments which gave no relief. His tonsils were removed at the age of four. Past history revealed he had chickenpox, mumps and measles when he was younger.

On initial examination he had a temperature of 99° and weighed 64 pounds. Physical examination was essentially negative except for the fact that the patient limped on the left leg and there was visible swelling of the left ankle anterior to both malleoli. At this time fluid was removed from the ankle joint and this revealed only seven white blood cells per high power field. Cultures were negative both in aerobic and anaerobic media. Antistreptolysin blood titer was 166 Todd units. The sedimentation rate was 23 mm. in one hour on the Westergren scale, and he had a perfectly normal hemogram. Roentgenograms of the ankle at this time were interpreted as negative. He was checked at approximately one month intervals, and the left ankle at times was definitely swollen, very tender, and any motion of the ankle produced pain. There was no evidence of fluid obtainable on any subsequent examination. At frequent intervals he had a temperature which ranged from 99 to 102°F, although ENT examinations revealed no positive findings. On June 9, 1954, however, another aspiration of the ankle joint was done and five cc. of bloody dense fluid was obtained. The cultures and animal injections done at that time were en-

tirely negative. On October 11, 1954, the patient had developed increased pain with a mass appearing on the anterior medial aspect of the talus which was quite tender, and continued to enlarge since it was first noticed about three weeks previously. He was unable to walk on this foot due to increased pain; it was then that the biopsy of the tumor of the talus was carried out.

Roentgenograms taken at that time revealed some moth-eaten areas of decreased density as well as a few areas of periosteal proliferation on the neck of the talus. The body of the talus seemed to be well involved with the moth-eaten areas (Figure 1). The biopsy which was carried out under general anesthetic revealed a mass of pink, almost fish-flesh colored material which seemed to be beneath the ankle joint capsule. One opening the ankle joint capsule, the friable mass, which was 4 x 2½ cm. in size protruded into the wound. It seemed as though the entire talus was involved with this tumor. A posterior plaster splint was applied and a dry dressing applied. The father took the patient out of the hospital two days later and follow-up revealed that patient expired one year later with no autopsy being obtained.

Microscopic examination presented a uniform picture. The tissue is made up of sheets of dark blue staining cells approximately twice as large as an adult lymphocyte. The nuclei of the cells appear much larger than normal cells with very little accompanying cytoplasm. Only a few mitotic figures were to be seen. Numerous nucleoli as well as irregular strands of chromatin were in evidence. Many endothelial lined spaces were seen, which was taken to represent increased vascularity of the tumor. Tumor emboli were in evidence in several of the larger endothelial lined vessels, which appeared to be of arterial origin. Rosettes and pseudo rosettes were in evidence surrounding the larger blood vessels.

Figure II. Reproduction of roentgenogram of ankle showing sclerosis and mottling of the os calcis.

Case Report II

F.D.H.—The patient was an eight year old white male who was first seen on April 15, 1954, complaining of pain in the left heel which had been intermittent in character for a period of about one year. At the time of onset he gave a history of having gone down a slide and injuring his heel. The patient had been seen by a doctor with a diagnosis of bruised heel but denied any laceration, contusion or abrasion. Roentgenograms taken at that time were entirely negative. He had had some night cries but these had never been with severe pain; this was usually relieved considerably by heat and to some extent by aspirin.

Past history revealed that he had had frequent infections of the tonsils during the previous two or three years, but he had been gaining weight and feeling very well with no other joints involved at that time.

Examination revealed that he was a well nourished, well developed white male who did not appear acutely ill and could walk. Examination was entirely negative except for the left foot and ankle where there was generalized swelling throughout the region of the left ankle and forefoot with pain on motion of the ankle in any direction, but especially on inversion. He had point tenderness on the lateral and posterior aspects of

the heel but there was no localized area of redness or heat. The roentgenograms were essentially negative. The sedimentation rate was 16 mm. in one hour on the Westergren scale; the hemogram was essentially normal, and the urinalysis was normal.

The patient was admitted to the hospital on May 4, 1954 due to an increase of pain in his foot which had required hypnotics at times for relief. His temperature had been normal. There was no lymphadenopathy. The foot was especially swollen about the heel with considerable tenderness on pressure about the heel. Antistreptolysin titer was 625 Todd units; the sedimentation rate was 40 mm. in one hour; the urinalysis was negative; the white count 5,450 with 50% neutrophiles, and 41% lymphocytes. Roentgenograms taken again were entirely negative. He was dismissed from the hospital four days later on May 8th. He was seen at frequent intervals and appeared to be doing very well other than the fact that there was a continuation of swelling in the foot and pain on motion; he was unable to bear weight on it. His temperature was 99.2°F. on several occasions. On July 28th, 1954 he was placed in a walking boot cast with very little relief. Roentgenograms made on August 25, 1954 revealed there was extensive mottling and a loss of normal bone detail in the entire os calcis (Figure 2). There was a thinning of the cortex of the body superiorly. He had had no febrile episodes. He was admitted to the hospital at this time. An electrocardiogram was negative. Anaerobic and aroebic cultures were negative. Cultures were done on Petragnani media which, after six weeks time was negative. He continued to run a temperature of 99 to 100°F. A biopsy was done on September 8, 1954 which revealed the bone and cortex to be of mushy-like consistency with a milky secretion on the under surface of the periosteum.

Microscopic examination of the tissue revealed that all normal histological features were destroyed. The tissue was replaced by cords and strands of basophilic, hyperchromatic cells, whose nuclei were enlarged and contained many nucleoli. Numerous mitotic figures were in evidence. Marked vascularity was to be noted with very scant stroma in evidence. Rosettes and pseudo rosettes were conspicuous by their absence.

Postoperative course following the biopsy was entirely normal and the patient was dismissed from the hospital to be given extensive radiation therapy, following which he developed numerous metastases to the chest and hips. The white blood count decreased to 3,000. The patient became blind in both eyes, and numerous pelvic, chest, and hip metastases occurred, and patient expired within a six months period of time.

Summary

A review of the literature has been made revealing only 11 cases of Ewing's sarcoma in the foot. Case reports of Ewing's tumor in the talus and os calcis bones of the foot have been added.

BIBLIOGRAPHY

1. Ewing. Further Report on Endothelial Myeloma of Bone. Proc. New York Path. Soc. 24: 93, 1924.

2. Lichtenstein. Bone Tumors. 1952. C. V. Mosby Co.

3. Lichtenstein, L., Jaffe, H. L.: Ewing's Sarcoma of Bone. Am. J. Path., 25: 43, 1947.

4. Wang, C. C., Schults, M. D.: Ewing's Sarcoma. New England J. Med. 248: 571, 1953.

5. McSwain, B., Bird, B. F., Jr., and Inman, W. A., Jr.: Ewing's Tumor. Surg. Gyn. and Obst. 89: 209, 1949.

6. McCormack, L. J., Dockerty, M. B., and Ghormley, R. K.: Ewing's Sarcoma. Cancer 5: 85-99, 1952.

7. Morton, J. J. and Duffy, W. C.: A Clinical and Pathological Study of Ten Bone Tumors. Arch. Surg. 7: 469, 1923.

8. Christenson, Frederick. Ewing's Sarcoma. Ann. Surg. 81: 1074, 1925.

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ABSTRACTS

Wound Healing: Investigation of Proteins, Glycoproteins, and Lipids of Experimental Wound Fluid in the Dog

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Proceedings of the Society for Experimental Biology and Medicine **101**: 353-356, 1959

Surgical implants of stainless steel mesh cylinders were made into subcutaneous tissue of dog's back. These were removed at intervals of one to four weeks. Wound fluid was aspirated from inside these cylinders encapsulated with fibrous tissue. When compared with animal's serum, this fluid was lower in protein, glycoprotein, and lipid; and these components decreased with time during post-wound period. As studied by paper electrophoresis, wound fluid had a higher per cent of albumin and lower alpha-2 and beta-1 globulin. An elevation of protein-bound hexose was found in beta and gamma globulin fractions at three to four weeks. Seromucoid was present at same level in wound fluid and serum. The lipid partition revealed especially low phosphatides but similar cholesterol: protein ratios. It appears that time-related changes occur in large molecular constituents of fluid found in wound area which may be significant in wound healing phenomenon.

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The Oral Yeast-Lactobacillus Relationship I. Nonutilization of Hexosephosphates by An Oral Lactobacillus

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The Journal of the American Dental Association **58**: 64-69, 1959

These studies demonstrate that an intact, viable, actively metabolizing oral strain of L. casei cannot, or at best can only very slowly and ineffectively, utilize glucose, 1-phosphate, glucose 6-phosphate, fructose 6-phosphate and fructose 1,6-diphosphate, for growth or lactic acid production. The results are also relatively unaltered by either the presence or absence of an oral C. albicans filtrate. The apparent synergistic activity of the yeast and the lactobacillus cannot be interpreted on the basis of a complementary effect of certain glycolytic enzymes from each microorganism (as suggested by the earlier workers) inasmuch as the first and major premise of this theory was speculation that the lactobacillus can readily utilize the hexosephosphates in the place of glucose as an energy source.

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Posthemorrhagic Anemia and Shock in the Newborn

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Pediatrics, **24**: 97-105, 1959

Acute fetal blood-loss usually occurs during labor and delivery. This condition may be the second commonest cause for anemia in infants at birth. Although the causes for fetal hemorrhage are diverse, they result in a single entity, posthemorrhagic anemia or shock immediately after birth. The signs and management are essentially the same regardless of cause. It is suggested that "posthemorrhagic anemia and shock in the newborn" be an accepted and standard pediatric diagnosis. The infants are pale but have no hepato-splenomegaly or edema. If the condition is severe the infants have weakness, tachycardia and distress out of proportion to any degree of cyanosis. Pallor persists in spite of administration of oxygen. Under such conditions immediate re-expansion of blood volume is imperative and life-saving.

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Psychodynamic Factors in Munchausen's Syndrome

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A.M.A. Archives of Internal Medicine, **104**: 427-429, 1959

A case of Munchausen's syndrome is presented in which it was possible to study the life history and (to a degree) the emotional development of the patient. In view of these data, the bizarre behavior of the patient takes on meaning and fits into a reasonable psychodynamic formulation. In this particular patient, we have seen a person who very early developed difficulty in establishing rapport with his environment. This

was followed by a series of incidents, each of which, in itself, was not unusual, but which, in this patient, added up to the bizarre behavior. It should not be presumed that these same mechanisms are operative in all cases of Munchausen's syndrome. Further study of patients with this syndrome is needed before drawing definite conclusions regarding the etiology.

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Posthemorrhagic Anemia and Shock in the Newborn Due to Hemorrhage During Delivery

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Pediatrics, 24: 92-96, 1959

A comprehensive review of all aspects of posthemorrhagic anemia and shock in the newborn, based on the experience in this clinic and cases reported in the literature, has been provided in another paper by the authors.

Cases 1 and 2 represent examples of posthemorrhagic shock resulting from tearing of a velamentous insertion of the umbilical vessels. Case 3 is an example of fetal blood loss due to tearing of a vessel communicating between a succenturiate lobe and the main body of the placenta. Cases 4-7 in all probability represent examples of acute fetal blood-loss due to incision or disruption of the placenta. Although the source of bleeding was not recorded for Cases 2 or 4-7, a posthemorrhagic state could be presumed by the condition of the infants and the coexistence of obstetric conditions with which fetal bleeding is commonly associated. Case 8 is an example of acute fetal blood-loss due to disruption of the placenta after uterine rupture.

*National Institutes of Health.
**Professor of Pediatrics

General Principles in Treatment Of Injuries to Athletes

DON H. O'DONOGHUE*

The Journal of the AMA, 171: 1656-1659, November 1959

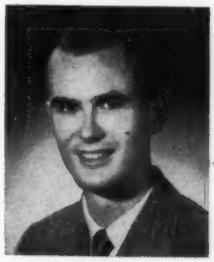
Experience has led to the conviction that a physician called on to treat an injured athlete should respect the patient's desire for early return to a competitive status. The physician's examination should be thorough, and treatment from the beginning must aim at the complete rehabilitation of the athlete.

*Professor of Orthopedic and Fracture Surgery.

New Faculty Appointments

Recent appointments to the School of Medicine faculty include new members of the departments of Medicine, Pediatrics, Anesthesiology and Preventive Medicine and Public Health.

Newcomers to the Department of Medicine are Stephen Wright Thompson, M.D., and Natoo C. Patel, M.D., instructors.


THOMPSON

Doctor Thompson, who received his M.D. in 1951 from Ohio State University, interned at University Hospitals and served an internal medicine residency at the Medical Center, then took a residency at Baylor and returned here last year for further residency work in neurology at the Oklahoma City Veterans Hospital.

He is doing research on the determination of regional blood flow by surface counting of radioactive tracers.

Doctor Patel, a native of Bombay, India, came to the Center from the University of Colorado Medical school where he was chief resident in medicine the past two years. A graduate of Podan Medical College, Bombay, he subsequently received a master of science degree at the University of Colorado. He has taken additional residency training in medicine, pathology and cardiology.

Named to the Department of Pediatrics were George Bouthilet, research associate, and Leon Horowitz, M.D., Tulsa, visiting lecturer.

Joseph Louis Martin, M.D., is a new clinical assistant in the Department of Anesthesiology; and Everett Neal Holden, M.D., in the Department of Preventive Medicine and Public Health.

Special Articles

PROFESSION OR BUSINESS?*

J. H. MEANS, M.D.,** Boston

MEDICINE, traditionally, has been considered to be a profession, even one of the so-called learned professions. Many definitions of profession can be found, but the idea common to them all appears to be that a profession is organized for service to humanity, whereas a business or trade is entered into for the sake of material profit. At first blush it might seem that there should be no confusion or overlapping between these, and I believe that until quite recently there has not been. The medical profession especially has valiantly put in writing its concepts of what constitutes proper professional behavior for the doctor of medicine. The late Willard L. Sperry, D.D., in his important little book entitled, "The Ethical Basis of Medical Practice," has this to say:

> Of all professional groups that of medicine has, on the whole, codified its ethics more rigorously than has any other of the kindred professions. Lawyers and teachers have their codes of ethical practice. In the former instance they are probably less rigorous, and in the latter instance more vague than in the case of medicine. As for my own profession, that of the ministry, unofficial codes of ethics are as numerous as the leaves of Vallombrosa, but they lack the authority of these other codes.

But as after Moses brought the Decalogue from God to man, lapses into the worship of Mammon came with increasing frequency, so also medical practice is presently slipping more and more from its high ethic into the behavior pattern of the market place. A nonmedical writer within a few months has even had the temerity to bring out a book entitled, "The Doctor Business." It is an item that is causing some disputation among reviewers. I believe, therefore, that it is appropriate in the Gay Lecture this year to examine critically to what extent and in what direction deterioration is occuring in the boundary that should separate profession from business in the realm of medicine.

Ethics

Let us begin with a look at some of the existing codes of ethics. The oldest and most famous in our vision of history is the Oath of Hippocrates. I assume that you all know it by heart. There were others before it among the Egyptians, Sumerians and Babylonians. But for us the take-off is customarily from Hippocrates. The significance of

*The George W. Gay Lecture, delivered at Harvard Medical School, May 13, 1959.

**Jackson Professor of Clinical Medicine, Emeritus, Harvard Medical School; honorary physician, Massachusetts General Hospital.

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the Oath of Hippocrates, composed in the fifth century B.C., is that in its major principles and in its spirit, it is perfectly valid today. It is a noble utterance. To be sure, Hippocrates swears by Apollo and some other deities, which we don't have to do, but recall that Jesus told us not to swear at all —merely to tell the truth. So we are free to affirm the substance of the Hippocratic Oath, and what's more, to govern our professional lives by it.

The "Principles of Medical Ethics" promulgated by the American Medical Association, as far as it goes, is also an impeccable document. I can subscribe to nearly all of it. It has been through various versions. In the last one—1958—it has been reduced to a decalogue, almost as pithy as that of Moses. You should read it. The first paragraph of an earlier version of the "Principles" contains a statement that I like especially: "The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals." Some of the state medical societies have codes of ethics antedating that of the AMA.

Now, however, in 1959, we find ourselves in situations that make full compliance with the traditional ethical standards of medicine ever more difficult. Society has been overtaken by a socioeconomic turmoil with various innovations and reactions. These create all manner of new pressures, which push the doctor about until he is fuzzy enough not to be able always to distinguish between the ethical and the unethical. On all sides he sees business, unhampered by any of the principles by which he himself is bound, getting progressively more aggressive in the pursuit of profits through ruthless competition. He sees predatory advertising invading more and more systems of the social body—transportation, roadside and all the mass media. He sees chiselers and racketeers boring through the otherwise healthy social organism in a great variety of directions. He himself is forbidden by all his ethical tradition to engage in advertising, or to solicit patients, which amounts to the same thing, but he has to live and function in a culture ridden by advertising. Indeed, the function he serves is a vital part of that culture. Under these circumstances it is not surprising to find him sometimes making departures from his traditional pattern of behavior, and this he does both as an individual and through his professional organizations.

Nothing puts more strain on the doctor's ethics than financial matters. You may recall that St. Paul assures us that love of money is the root of all evil, and we all know that the more competitive a society, the more the power of money will be felt. Two of the new pressures that impinge on the doctor arise from the problem of how he shall be paid for his services and how, or in what manner, his services shall be supplied.

The traditional method of paying the doctor has been by fee for each service as rendered. When a patient could not pay the fee, the doctor nobly reduced it or waived it altogether. In an older, slower moving and less specialized society, this method has been satisfactory both to doctors and to patients. When practiced honorably it is certainly above reproach from the point of view of ethics. But that is not to say that in present-day society it is necessarily the *best* way, although it still seems to be so regarded by many doctors. But from the patient's side there is steadily increasing dissatisfaction with it.

A considerable number of objections to fee-for-service solo practice of medicine can easily be raised. It lends itself to abuse in various ways—fee splitting, for example. This is an ancient sin of medicine that is still with us, but I mention it in the present connection merely to illustrate again the ethical difference between profession and business. There is nothing unethical about the equivalent of fee splitting in business according to the ethical standards of business. It is merely granting a commision to someone who brings in more business. If a professional person, however, engages in such practices, it lowers his standards to those of persons who do business for profit. It puts the fee splitter in competition with other doctors and to trafficking with human life, health and happiness. Among other abuses we have such things as the rendering of a

service and charging a fee for it, when the doctor, although the patient may not know it, is not really competent to perform it. Even in Hippocrate's day this problem must have been rife, for he said, "I will not cut for the stone but leave that to practitioners of that work." On fee-for-service there is also the temptation to do unnecessary surgery or provide other forms of unneeded treatment to increase the income from fees.

From the patient's side, fee-for-service also may have the ill-effect of keeping patients away from the doctor when they really need his care, just because they wish to avoid the paying of fees. Indeed, the early diagnosis of disease and the whole matter of preventive medicine may become obstructed by the fee-for-service system. On prepayment, on the other hand, these services are included in the comprehensive program and create no such difficulty. On fee-for-service a conscientious doctor may be sore perplexed to draw the line between what is proper safeguarding of his patients by calling them in for check-ups, and what is exploiting them by insisting on unnecessary visits.

The progressive fragmentation of medicine into ever-narrower specialties also makes the furnishing of comprehensive medical care on the fee-for-service solo-practice basis increasingly difficult. When one doctor could do nearly everything and people for the most part stayed put for long periods, this was quite easy. The day when that sort of thing was possible, however, is past. Although one generalist can still do much of it, he will frequently need help from specialists, often several in a single case, and when all these bill the patient independently, it imposes a quite unnecessary hardship on him. It has driven some patients to go on their own initiative directly to specialists, very probably the wrong ones, without either patient or doctor knowing that they are the wrong ones. Not infrequently nowadays patients engage in what is known as medical shopping. They make up a list of specialists of their own choosing, quite probably on the basis of information from friends, and consult as many of them as they think indicated. They may think that in this way they are getting adequate medical care, but they are not. Some of their parts may be cared for, but not they themselves. The specialists involved may not even have any communication one with another about the patient's problem, and in any event no one doctor is taking the responsibility of integrating the total care of the patient. Only an understanding personal physician can do that adequately.

It can be said, indeed emphatically, that one of the major ethical principles of medical practice is that the doctor must be alert enough to perceive his total responsibility in every case and have the determination to meet it fully. His responsibility even continues after death, because when a patient of his dies, it is his duty to make every effort to obtain an autopsy. The reasons for this are both scientific and moral. Scientifically, it is valuable always to have autopsies because clinical impressions will be checked against indisputable material evidence, and because there is always the chance that something new will be learned. It is morally important to have an autopsy because it takes courage on the part of the doctor to face one. The knowledge that he will have to do this puts him on his mettle always to give the best care he can. It is not good medicine to bury one's mistakes, sight unseen.

When skills other than his own are needed in the care of his patient, the doctor has the responsibility of obtaining the aid of others who can supply them. That is to say, he must call in consultants. Any reluctance to do this is unethical.

It is not enough, however, for doctors either as individuals or collectively, merely to avoid being unethical, to stay only within the letter, but not the spirit of the ethical code. "Such ethics," a philosopher, A. E. Meyer, has recently said, "should rather be called practical rules to get along in life; they are selfishness brought into harmony with the demands of others, who claim equal rights and are willing to enforce them. It is the kind of ethics that has presented itself in international politics, demanding a world organization to prevent future wars."

Is the medical profession today morally bound to go beyond this sort of thing and voluntarily take certain positive actions to

improve the provision of medical care in the country at large? If so, is it doing this? Of course, these questions can be evaded by asking whether there is really any need or room for improvement in the medical-care establishment of the United States. I hope that what I have already said will have convinced you that there is—from the point of view not only of getting integration of divers skills in giving care but also in putting payment for care on a basis financially fairer and more equitable to patients than the presently prevailing system of solo practice and fee-for-service, with free choice of doctor.

If actually there is room for improvement, what line shall it take? Probably there are several possible ways, and the indication is to try some of them out and discover what they have to offer. This actually is already being done in a somewhat spotty fashion, but only with vigorous opposition from organized medicine. A minority of the profession, but one growing in size, believes that the provision of medical care largely by groups of doctors, organized to include a proper proportion of generalists and specialists, and paid for their services on a prepayment plan of some sort, offers many advantages to both patients and doctors over the present system.

It is not my purpose, however, to discuss the pros and cons of any plans for the improvement of medical care at this time, and I am sure it would be unethical for me, within the framework of a Gay Lecture, to try to persuade you to take a particular side in a controversial matter. I wish merely to indicate the ethical principles that I believe to be involved. This can readily be done by asking the rhetorical question, What kind of ethics is it when organized medicine resorts to boycotting, lobbying, and other pressure tactics when honest attempts are made to improve medical care in the organizational and payment realms of medicine? What kind of ethics is it also when a county medical society not only refuses to co-operate with a group health plan being set up in its area by doctors of competence and integrity but instead does its utmost to scuttle it? In such a case the health plan bids fair to raise the quality of medical care and make it more generally available. The people want it, but the medical society fights it just the same. This sort of thing happens repeatedly. Such self-protective behavior is expected in business. It has no place in professional work of high ethical character.

The distinguished jurist, Mr. Justice Frankfurter, who gave the Gay Lecture a year ago said, "My profession is pretty bad . . . but I am bound to say that I should be a little troubled if my profession lined up an advertising agency to work out its relations with the government." This refers to the episode in 1950 during the Truman administration when the officials of the AMA raised an enormous "War Chest" to fight what they called "Socialized Medicine" and hired the advertising firm of Whitaker and Baxter to do it for them. They were for the moment successful, but at the cost of adopting behavior patterns more suitable to business or politics. The point I should like to make is that organized medicine should abide corporately by its code of ethics as assiduously as it expects its individual members to do. Any double standard in this regard is intolerable.

Thus far we have been considering ethics largely in relation to the care of patients, or practice of medicine in the usual sense, but medicine in its entirety encompasses much more than that, and ethics is involved also in these wider reaches. May I again recall the wisdom of Frankfurter. "I am not competent," said he, "to have any views on the very difficult problem of the relations between the medical profession and society. But the notion that it is just an individual affair between a patient and a doctor seems to be totally discredited by all we know." Justice Frankfurter has indeed here given us a strong hint of the multidimensional nature of our professional commitment, which, if heeded, cannot but intensify our interest and deepen our understanding both of our obligations and of our opportunities. Doctors, particularly organized doctors, are inclined to entertain the naïve belief that they are quite competent to appraise objectively their own profession. But since medicine is one of the vital functions of the social organism, of concern to all its members, this professional insularity has no valid vindica-

tion. It is significant, I think, that in the long list of Gay Lecturers we find a goodly number of disciplines other than medicine represented. This has been particularly true in recent years. We are getting, it seems, increasingly willing to see ourselves as others see us. Indeed, starting from today, we have to go back five years to find another physician as Lecturer. A lawyer, a psychoanalyst, two parsons and a writer intervene. This is all to the good.

This vista discloses another great ethical principle — namely, that medicine is for everyone. It is not a private game preserve for doctors. And how much greater is the happiness to be got from it if it is practiced in a generous spirit! Where doceors develop a proprietary interest in their patients, as believe me they sometimes do, they downgrade medicine to the level of business.

Medical Education

Let us now explore for a moment another great function of medicine—namely, teaching—and see what ethical principles may be involved in it. The medical profession is obligated to educate its own successors. Should it not do this the profession would die, for no one other than doctors of medicine can complete the education of doctors of medicine. The first stipulation in the Oath of Hippocrates is "to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and disciples bound by oath and stipulation, according to the law of medicine, but to none others." In modern parlance I think we may interpret this to mean that we have the obligation to teach, whenever the opportunity presents, anyone rightfully involved in the medical educational process if he so desires it.

Not only have we this teaching obligation, but if we are in medicine because we love it, we should desire to do it. We should derive happiness from it. The relation between teacher and pupil can become as meaningful and endearing as that between doctor and patient. And the medical teacher is challenged above all others because he has to meet the needs at the same time of both pupil and patient when the latter is the subject of instruction, nor can he allow the best interest of the one in any way to infringe upon that of the other.

Another point is well illustrated by the oft quoted lines of Chaucer, "and gladly would he learn and gladly teach." Where can one find a nobler precept for medicine than this? It puts learning before teaching, and how wise this is, because teaching at its best is no more than the facilitation of learning. I was extraordinarily happy three years ago at being enrolled a "Perpetual Student of the Medical College of St. Bartholomew's Hospital" (London). The word perpetual is the significant one in this charming epithet. It implies, or at least expresses, the hope that one may continue to be able to learn as long as he draws breath. So I pray may it be with all of us.

It would not seem likely, offhand, that there had ever been fee-for-service problems about paying for instruction by students, comparable to that for medical care by patients, but such has indeed been the case. Of course, in the days when medical schools were not available to all wishing to study medicine, there was the apprentice system, but that is not what I have in mind at the moment. In the eighteenth and early nineteenth centuries, students in medical schools paid fees for instruction directly to their professors—a fee for each course of instruction. The great John Hunter's fatal attack of angina pectoris was induced by a quarrel with other members of the staff of St. George's Hospital over a problem of fees paid by students to teachers.

At Harvard also in the eighteen forties, students paid fees directly to their professors for courses of lectures and were given tickets of admission. For the course in anatomy and operative surgery by Doctor J. C. Warren they paid $15, and for that on materia medica by Doctor Jacob Bigelow the fee was $10 and so forth. But all this is long

past history except perhaps in the case of certain graduate courses. Therefore, we may ask, if a better way than fee-for-service has been found for paying for instruction, why should not a better way than this be found also for paying for medical care?

We have today, moreover, an ethical problem concerning medical education at the collective level. The population, as you well know, is increasing at an explosive rate, and the need for well trained doctors is shooting upward. Medical education is the most costly of all education, and our medical schools are sorely pressed financially. No adequate aid is in sight short of federal subsidy. Yet organized medicine is so hostile to any further extension of government into medicine that it has opposed vigorously any help by the federal Government toward cost of instruction in medical schools.

Research

The second precept of the AMA decalogue tells us that "Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments." Certainly, we can all say, "Amen" to this. The chief instrument to improve medical knowledge and skill is research, and this is another of the great functions of medicine. If without education we have no new doctors, so without research we have no progress. If we can say, "and gladly teach," so too we must say, "and zealously investigate." There are some ethical considerations about research that need to be mentioned.

The first of these is that the investigator must be scrupulously honest in all he does, both intellectually and in every other way. Complete objectivity is an absolute necessity. One should undertake research to test hypotheses, not to prove them. The object is to find the truth without bias or slanting of data. When a research is undertaken to discover whether cigarette smoking causes cancer of the lung, and is financed by tobacco interests, its results cannot but be suspect. Great temptations lie in the path of the investigator. Let us suppose he discovers something of importance—perhaps a new form of therapy. He tries it out on patients (after having done so first on animals). Its administration is followed by improvement in some of them. In reporting his results he is under great emotional pressure to see the good results through rosy, and the bad through dark glasses, or to classify as good that which is actually equivocal. Results of research seemingly important should not be accepted as fully valid unless confirmed by other investigators. Never forget that in research adequate control of all observations and experiments is mandatory, and that in clinical research on patients it is sometimes very difficult to achieve.

Another temptation is to utilize research for purposes of personal advantage or advancement. This really is a tough one because the habits of faculties are such that a regrettable amount of weight is put on how much a man has published. It would hardly be human not to like success, recognition and fame in research, but these should not be ends in themselves, but merely pleasant by-products. Nor should we in medicine keep our findings up our sleeve, as does business its trade secrets. At all stages of investigation we must be willing to exchange information with colleagues. This precept is indeed directly implied in the AMA's "Principles" (Section 2). Priority is dear to the hearts of all investigators, and why not? It is very commendable to be the first to uncover some new truth, and one may get a Nobel Prize for it, but the goal should be the new truth, not the kudos of priority. Moreover, in all research conducted in the professional spirit, investigators should give freely and generously full credit to other investigators whose work is in any way relevant to their own. To repeat the work of others without prejudice and publish findings with complete honesty is right and proper, indeed necessary. To belittle it in order to build up your own is, in the professional way of life, ignoble. In business, on the other hand, it seems to be rather normal, or at least frequent. Actually, to most discoveries many investigators contribute, and all deserve credit for what they have done.

Pharmaceutical Advertising

Increasingly in these days medicine is being confronted with difficult questions in ethics through the impact of the pharmaceutical industry. Its advertising infiltrates our medical journals, and many of them could not survive without the income it brings in. Practitioners receive daily through the mail vast quantities of multicolored beguiling advertising literature, well laced with free samples of decorative and expensive pharmaceutical preparations with trade names often difficult of comprehension, and complete with directions how to use them and with hand-picked bibliographies. For the doctor to prescribe such material solely on the recommendation of the manufacturer is to slight, in some measure, his duty by his patient. The rightful way for him to order drugs is to discover, from objective sources, their composition and pharmacologic action, and order them only to meet indications for treatment that he clearly recognizes. Then there are the detail men, usually delightful and co-operative fellows, who give you more advice and free samples, which, if you accept them, influence you somewhat to favor the detail man's house in your prescription writing.

The other side of the picture, however, is that the more reputable drug houses have made great strides in raising their ethical standards, and have done invaluable work in devising and testing new drugs in their research departments. They can get high-grade investigators because they can pay better salaries than universities or noncommercial research institutes. Furthermore, so lucrative has the pharmaceutical industry become, and so enlightened, that it makes larger and larger grants-in-aid to noncommercial research projects. Thus, even the universities become beholden to some extent to the industry. How good this is I confess I don't know, but I am strongly of the belief that it is necessary for medicine to work toward some form of ethical symbiosis with the pharmaceutical industry, if this can be done without compromising our own ethical standards. This is necessary because the industry can produce new scientific knowledge that medicine simply cannot afford to do without.

Patents

And this brings us to a special subject that sharply emphasizes the difference between business and profession—namely, patents. If a medical investigator develops a new drug or method, he is ethically bound to tell the professional world about it. He is prevented by his own ethical standards from patenting it. But if a drug house does such a thing, it would be, by business standards, insane not to apply immediately for a patent. But unless a discovery of noncommercial research is protected in some way, industry may patent it and make profits out of something to the discovery of which it has not contributed. Some ways have been found to escape from this dilemma. Patents can be taken out to protect a product, but dedicated to the public. This ensures that no one can gain a monopoly in its production. A well known example was insulin, which was patented by the University of Toronto to ensure its availability to all without anyone having any special privileges.

The Press

Another somewhat special topic is the press and other mass media. In the past the doctor has been supposed to keep himself out of the press as far as possible, at least not to use it as a means of popularizing himself. But nowadays when he cares for VIPs, he cannot keep himself out of the mass media, and this through no fault of his own. Also, often he is pushed into public writing or speaking by the institutions with which he is associated—hospitals, medical schools and so forth, which have money-raising campaigns under way and want him to glamorize what they are doing for the advancement of medical science.

All the mass media also carry a steadily increasing volume of medical items, purportedly for purposes of public education. Some of these are excellent; some are dreadful. The great question is whether the total impact on the public of all this is good or bad. When it provides the stimulus that brings the patient to the doctor while his serious

disease is still curable, it is good. When it leads to the pressurizing of doctors by patients to give treatment the doctor knows is not really indicated, it is bad. It has come to pass nowadays that patients, having soaked up some of the mass-media pronouncements, go to the doctor and tell him how to treat them. "Doc, I want a shot of penicillin." The doctor may know that this is neither needed nor desirable, but he also knows that if he doesn't give it, the patient will be off to another doctor who will. So the first doctor may give it even against his best judgment. Actually, he is on a hot spot. Of course in this case the ethics is clear enough. He should refuse to give it even though it means the loss of a patient. If he were not on fee-for-service there would be less of a problem.

The mass media can be very damaging also to the investigator. They will quote him out of context, give undue emphasis to parts of his remarks, and let headline writers commit veritable mayhem on what he has actually said: "Great breakthrough in cancer just around the Corner," and all that sort of rubbish. Beware of them!

The Patient and the Truth

A very controversial ethical question is that of truth telling to patients. You will find entirely reputable and earnest doctors who believe in lying to patients when it is, in their opinion, to the patient's good. The other extreme is best typified by the late Doctor Richard C. Cabot, of Harvard, who believed that the doctor should always tell the patient the truth, the whole truth, and nothing but the truth. This is a naïve position, because who ever knows, in the progress of a patient, what the whole truth is? I am sure some of the "truth" that Doctor Cabot told just wasn't so. For him things were either black or white, but the world is mostly gray. Personally, I am thoroughly opposed to the intentional practice of deceit in doctor-patient relations, but also I have constantly in mind the admonition of Oliver Cromwell, who said, "by the bowels of Christ my brethren bethink you, you may be mistaken." Also I cherish the dictum of the late Lawrence J. Henderson, "in the practice of medicine do as little harm with words as possible." Thus, I would say, beware of making traumatic remarks within the hearing of patients that they have neither asked for nor need to know. I am sure that this is one of the commonest professional sins that any of us commit. Beware particularly of ever making a prediction of how long anyone is going to live. Nature is capable of letting you down badly. Many a patient has outlived the doctor who "gave him but a year to live." Remember always that it is not what you say to patients that is important, but what they think you said. Your silences also may be as traumatic as your words. How often does a patient when asked, "What did the doctor tell you?" reply, "He didn't tell me anything!" The wise doctor will sense when the patient needs to be told something, and he will do this in as reassuring a way as the basic framework of truthfulness permits. Do not be afraid of saying, "I don't know," when that is the truth. Moreover, always be ready to listen, and to answer questions as wisely as you can.

Related to what you shall say, or not say, to the patient is what you shall say, or not say, about him to other people. Hippocrates puts us straight on this without need of alteration or interpretation: "Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken, I will not divulge, as reckoning that such should be kept secret."

Another ethical or moral question, quite shocking in nature, is what we shall do about the elderly or hopelessly ill patient who longs for an end to his suffering in death. Shall we let him die, merely easing symptoms as he goes, or shall we force him to suffer yet a little while longer because science has given us such things as antibiotics and oxygen tents that will do this. Euthanasia, as you well know, is a hotly debated matter. Whether it may or may not be practiced is for society, not the medical profession, to decide. It is within the doctor's prerogative, however, to determine what treatment he will or will not use, and if under the type of circumstance I have indicated, he elects not to use the life-prolonging methods, can any honest and reasonable person say he has done

wrong? "Lord, now lettest thou thy servant depart in peace, according to thy word," so said St. Luke, "the beloved physician," and he expresses my own thoughts on the subject perfectly.

Discussion

I will finish this discourse with a few more transcendent considerations. Medical ethics is, I suppose, a part of ethics, and ethics certainly is a branch of philosophy; therefore, we may philosophize a bit. I am sure few, if any of us, are philosophers, but it is given to any man to apply his own homely philosophy to what he is doing and see what he can come up with in the way of convictions, motives and satisfactions. Recognition of these qualities of mind comes through insight, and certainly no one needs insight more than the physician. "Physician, know thyself" is perhaps the simplest way to put it. Although in a profession, especially in those called learned, of which medicine is one, the less conformity is required the better, nevertheless when in the practice of such a profession the lives, welfare or happiness of other people are involved, it becomes necessary for that profession to impose upon itself, or when it fails to do this for society to impose upon it, certain minimal standards of competence and certain rules of minimal acceptable professional behavior. It is these necessities that have given rise to the codes of medical ethics of which we have been speaking. I am convinced, however, that if a physician is of good conscience, there is little likelihood that his behavior will sink to a level where the ethical code need be called into play to correct it. At least this is true so long as he acts as an individual and follows the dictates of his conscience. If he has no consicence, he should not be in medicine. Unfortunately, as we have seen, when he organizes and acts collectively, the conscience of the herd, through a homogenizing process, may become sufficiently benumbed to permit some deterioration in ethical standards.

The quality of medicine in the mass, however, will depend largely on the motivation and character of the individuals who serve it, and the chief point I want to make is that the highest motivation possible is that one shall love medicine and find happiness in performing any of its many functions. This is indeed the essence of professional motivation and of what determines the professional way of life. It is what sets the profession in a higher ethical bracket than occupations entered merely to make a living. To be sure, the doctor must have an income sufficient to permit him and his family to live comfortably and happily, and to have enough leisure to keep in close rapport with the culture in its various dimensions. There is usually no great difficulty about this. It is a setback for medicine, however, when the doctor permits himself to become intellectually and emotionally isolated.

As I look around at my many friends in medicine—those who are older (not so many of these now), contemporaries and the steadily growing number of younger ones, many of whom have been my pupils—I am increasingly convinced that those who get the most out of medicine, and more particularly those who give the most to it, are those who love it. Medicine is indeed a profession—not a business. Let us keep it so.

And in conclusion I again quote Hippocrates: "While I continue to keep this oath inviolate, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times, but should I trespass and violate this oath, may the reverse be my lot."

Vicarious Wish Fulfillment for Young Boys and Old Boys

JOSEPH J. QUINN*

GEE! It's been three years this week since we rode in the cab of the Santa Fe Chief. Three years! But we shall never forget the thrill and the hospitality. So many people have asked us to rerun the article so that they, too, can partake of the unusual experience. Well, here it is:

Whooooooooooo! We were sounding the horn (siren) on the Texas Chief, crack southwestern limited, running between Chicago and Galveston.

Ever since boyhood days we have always wanted to ride in the cab of a locomotive. But when the locomotive went out, we knew we didn't have a chance to ride in the cab of a diesel streamliner. But we did—and how!

It all started back in August when we wrote a piece about the disappearance of the trackwalker. Robert F. Emmanuel, Division Passenger Agent of the Santa Fe, wrote us and explained that the trackwalker had disappeared because they now have a mechanical track detector. At the same time he invited us to visit the Santa Fe Operations Office in Arkansas City. Not being technical, we wrote in this column that we should prefer to ride in the cab of a streamliner.

Nothing happened for several weeks. Then Mr. C. W. Lane, Public Relations Director of the Santa Fe asked us to come see him. "So you want to ride in the cab of a streamliner? That might be arranged but it will take time. How would you like to ride the Texas Chief to Texas?" That suited us just fine. Lots of red tape. In fact, it's more dificult than to get a visa to behind the Iron Curtain. Nobody rides in an engine cab except top railroad officials and once in a great while a newspaperman.

Mr. Lane's assistant, Gilbert (Gil) Sweet, as fine a young man as you would ever want to know, helped make arrangements early last week. He was to escort us to Gainesville, Texas, and ride in the cab with us. Last Friday morning there were several railroad officials, including Mr. Emmanuel, at the station. We were introduced to everyone. The Texas Chief rolled into the station with 16 cars—a heavy load. We climbed that perpendicular ladder for 10 feet on the recessed steps. (That was the hardest part of the trip.) Then we met the engineer, E. J. Fitch of Arkansas City and the fireman (second engineer) J. R. Conrad, of Ark City. Also the road foreman of engines, W. H. Hoster of Newkirk. As only four persons are permitted to ride in a cab, Mr. Sweet rode in the lounge car.

The cab is a small place and it smells of oil and compressed air. We were taken back into the first unit and had the compressors, generators, etc., explained to us. Then came two sharp whistles. The units became noisy. The fireman shouted "Highball!" and we were off, sand on the spinning wheels.

Up there in the train's magic eye everything looked different. The engineer's cushioned seat is 11 feet above the ground. We stood by the window and watched the train roll, watched it gather speed. Traffic stopped at crossings as the train sang its song to keep out of the way. Then came Norman in a jiffy.

Down near Purcell Engineer Fitch said, "Wanna blow the horn?" "How many times?" we asked. "Make it four for this curve." We gave it two mediums, a short and then hung on. The engineer smiled and remarked "You oughta been a railroader." Then we asked "When are you going to hit ninety?" "Just a little way off," he said. We watched the needle. Seventy, eighty, eighty-

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five and then ninety for about three miles. The engine rocked and rolled at ninety—the speed limit. We were sorta happy when he pulled it back to 85.

All along the trip, back and forth to Gainesville, the engineer and fireman kept shouting "Clear block." That's when they saw the green light ahead. One would shout, the other salute and repeat. The same way with the speed signs. One would sing out "70" and the other would echo "70." The engineer was always busy, twisting throttles, testing the brakes, pulling the siren rope and holding his eye on the road like an eagle. He keeps his foot on the "Dead Man Control" all the time. If he takes it off for 10 seconds, the train comes to a shuddering stop. That's to protect against heart attacks, etc.

You can talk about your foliage tours but we had a breath-taking one going through the Arbuckle mountains. The diesels twisted and turned around cliffs where red sumac was clinging for life. The maples were crimson on the hills and the oaks hugged the hollows in yellow hues. Below, the river ran brown and tawny from morning rains. Intermittently the sky was cloudy, then blue, then gray. But the Arbuckles were a riot of colors that raced by like pieces of silk thrown high into a wind.

At Purcell we changed crews. Engineer E. R. Erneike of Cleburne and Fireman J. C. Cox of Cleburne took charge. But we also had a V.I.P. on board. He called our name; knew all about us. He was O. D. Crill of Fort Worth, Superintendent of the northern division of the Santa Fe. He has his own special car, secretary and chef besides his Fort Worth office. But he rode to Gainesville with us in the cab and was a boon companion. Down across the Red River, we opened up to 80 through the plains. Then came to Gainesville. We climbed down, and were a dinner guest of Gil Sweet, together with Mr. Crill.

Two hours later we climbed into the cab again on the Texas Chief going north to Chicago. This diesel had a steamboat siren —and a loud one. Passing through stations, people put their fingers to their ears. The engineer was F. Webb of Gainesville and the fireman, L. H. Himmelreich of Cleburne. Mr. Crill also accompanied us in the cab back to Purcell where his private car was waiting.

Biggest Cinerama thrill of all was to cross a steel covered bridge going 80 miles an hour. You feel as if you will strike the supporting beams. Then you're over the river and the wooden ties appear like a black carpet unfolding before you. There seemingly is no space between them. We watched through the rear view mirrors and saw our end coaches swinging around the cliffs. When the last one was around the curves, the fireman would shout "All clear." Then the engineer would work the throttle and the train would lurch with gaining speed.

At Purcell we had the happiness of our first crew returning for their run to Arkansas City. Both Engineer Fitch and Fireman Conrad are the jolly type. They kept up a running fire of conversation.

Twice on the trip we held our breath. Down near Gainesville, a driver paused with his car on a country road. Then he stepped on the gas in order to beat us to the crossing. He escaped with his life by one second. The engineer shouted (because you have to shout in a diesel) "Some people want to be killed." Another time a huge gasoline truck was running fast for a crossing. Engineer Fitch touched the brake lever, and held the horn cord down, then shot single blasts, a dozen of them. The truck finally stopped four feet from the train. The engineer smiled and said to us "You came mighty close to being in heaven tonight."

Darkness fell at Norman. Coming into Oklahoma City the world was brown with dust. The panorama of the city at night is something to remember from a diesel cab. Red, yellow, green signs sparkled through the dusty air, trembling as if shaken by the wind. Skyscraper tops were lost, except for beacons. Then came the terrific hissing sound of the compressed air of applied brakes and the train glided like a jointed snake into the Santa Fe station. Our 280 mile trip was over—the most thrilling one we have ever taken.

Someone asked us if we wanted to do it all over again. Our answer was "No, sir, we have had our thrill and our fill."

Trends in the Distribution And Organization of Physicians In the Practice of Medicine*

L. W. MARTIN, Ph.D.

Assistant Director Economic Research, American Medical Association

THERE IS an old saying, "Two heads are better than one." An equally profound aphorism has it that "Too many cooks spoil the broth." These two observations underlie and help to explain much of the remarkable diversity which characterizes the organization of supply of goods and services in the United States. They relate in particular to the managerial, or more correctly entrepreneurial, conditions which affect the sizes of the business units in our economy. This point, I think, is quite pertinent to the organization of medical services in terms of the physician units supplying the services.

This is only one of many ways in which an economic analysis of the organizational arrangements for supplying medical services can be approached. Geographically the spatial arrangement and distribution of suppliers (physicians) may be related to that of the consumers of services, along with the communication and transportation patterns followed by these respective parties in achieving the provision of medical care.

Greatest emphasis, I believe, should be placed upon the diversity of organization which prevails and indeed thrives in the American economy. Spatially there are many different ways in which suppliers and consumers may be and are arranged in the American economy. The business organization is varied both among and within types. Additional elements of organization conceivably include the availability of ancillary facilities and services such as hospitals, laboratories, etc. The diverse methods of paying for medical care may also exert some influence. A much overlooked factor affecting industrial organization is the knowledge with which a good or service, as medical care, is consumed. The ramifications of the subject are manifold. It is not feasible to explore all of them in one brief talk; but at the same time silence should not be construed as ignorance of them.

There are certain broad questions to which I do not have answers and to which there may be no answers. For example, ought there to be more group clinics in the United States? Is a further increase in the number of group clinics likely? The first question is incapable of objective measurement; the second involves forecasting which can be done better the more one understands what conditions affect extension or contraction of this form of organization and the more knowledge he possesses on how these conditions are behaving. The common assumption that answers to these questions do exist in strictly objective, numerical terms, is, I fear, without foundation in fact.

The Oklahoma Situation

Group clinics are evidently more common in Oklahoma than in the United States generally. The available data are somewhat fragmentary and to some extent incomplete. Fortunately or unfortunately there is not one set of data; there are at least three. In all these sets presented in a table—with explanation of the ways in which the data are qualified by date and by definition—we can

*Presented at the Oklahoma Health and Welfare Association Meeting at the Biltmore Hotel, Oklahoma City, on November 16, 1959.

see that various rates, ratios, or proportions are higher in Oklahoma than they are in the United States generally.

Physicians, Group Clinics and Physicians in Group Clinics, Oklahoma and the United States

	United States	Oklahoma	Oklahoma/ United States
Physicians*	211,654	2170	1.03%
Group Clinics			
AAMC**	134	3	2.23
NACM+	433	9	2.08
AMA++	960	41	4.27
Physicians in Group Clinics			
AAMC	2,344	40	1.71
NACM	5,835	99	1.70
AMA	10,597	260	2.45
Physicians per Group Clinic			
AAMC	17+	13+	n.a.
NACM	13+	11	n.a.
AMA	11	6+	n.a.
% of Physicians in Group Clinics			
AAMC	1.1%	1.8%	n.a.
NACM	2.8%	4.6%	n.a.
AMA	5.0%	12.0%	n.a.

*American Medical Directory, 1958, Table 3, page 13. Government service physicians are not included in these figures. The effective date of these figures is approximately May, 1957.

**The American Association of Medical Clinics reported 134 members in 1959. This organization defines full membership as follows: Seven or more full-time physicians maintaining a private organization for the purpose of providing general medical care of high quality. The group shall have on its full-time staff at least five physicians in different major specialties, two of which shall be Internal Medicine and General Surgery. A group should maintain a separate building or group of offices for the conduct of its practice.

+The National Association of Clinic Managers reported 433 member groups in 1959. It defines membership as follows: An organization composed of 3 or more licensed doctors of medicine engaged in the practice of medicine and operating on a private basis with pooled facilities, coordinated laboratories, x-ray and allied departments for the purpose of diagnosis and treatment of diseases, and which has as its administrative head a full time clinic manager in active supervision of its business affairs.

++The American Medical Association's Council on Medical Service has almost completed a survey. Thus the figures we report from it have to be characterized as incomplete. For the purpose of the survey the group was defined as having 3 member physicians. The American Medical Association House of Delegates on December, 1948 defined group medical practice as follows: Group medical practice is the application of medical service by a number of physicians working in systematic association with the joint use of equipment and technical personnel and with centralized administration and financial organization.

The percentage Oklahoma physicians are of all U.S. physicians is exceeded by the percentage Oklahoma groups are of all U.S. groups and the percentage Oklahoma physicians in groups are of all U.S. physicians in groups. Moreover, a higher percentage of Oklahoma physicians are in groups than is the case for all U.S. physicians. The average size of groups in Oklahoma, however, is smaller than in the U.S. Roughly, Oklahoma has about 1% of the physicians in the United States, but, depending on the source one uses, it has either 2% or 4% of the clinics and from about 1.7% to 2½% of the physicians in clinics. Similarly, the proportion of Oklahoma's physicians in clinics is almost twice as high as that for the United States for all three sets of data available.

From a geographical point of view, the provision of medical care is oriented around the two big cities in the state, Oklahoma City and Tulsa. According to the study which Frank Dickinson made using 1950 population data and medical service rather than political areas as the basis of his analysis, these two cities, only 100 miles apart, comprised what he called prime-primary centers, of which there were then 88 in the United States. Within the state, he additionally found 28 primary centers of which 15 surrounded these two prime-primary centers. This area is suggestive of a broad axis running northeast or southwest parallel to a line connecting Oklahoma City and Tulsa. Whether there are more or fewer areas today or there could have been more or fewer in 1950, I cannot say. One wonders if a small primary area adjacent to a prime-primary area might have been merged with the larger unit.

Using the largest estimate of the number of group clinics in Oklahoma, 41, I find that 14 of them are in the Tulsa and Oklahoma City medical service areas and 17 more are in the 15 surrounding medical service areas. Thus I find 31 of the 41 groups in these 17 medical service areas. Three of the surrounding areas had no group clinics. Ten group clinics may be found in the 13 remaining areas, 4 of which had none and 1 of which, around the city of Ardmore, had 2. Just as there would seem to be a concentration of medical facilities and group clinics around Oklahoma City and Tulsa, approximately in the middle of the state and perhaps a little toward the northeast, the areas without group clinics comprised 4 medical service areas, 1 in the northwest, 2 in the southwest, and 1 in the southeastern parts on or near the state's borders.

Interpreting the Data

Interrelationships between the business and the spatial arrangements need to be in-

terpreted with great care. The presence of group clinics a short distance beyond the state's borders may help account for their absence—in a few cases—from the Oklahoma border areas. Moreover the concentration of group clinics in Oklahoma's big cities presents a pattern apparently different from that in the United States generally. According to a survey currently being made by the AMA's Council on Medical Service, almost a third of the groups identified are in cities under 10,000 in population and more than half are in cities under 25,000. Interpretations of the data available for Oklahoma may have to be confined to Oklahoma rather than extended to the U.S. Indeed, many factors ought to be considered in interpreting and evaluating trends in the distribution and organization of physicians in the practice of medicine.

In any interpretation of data on the organization of medical care services some further questions should also be asked. What advantages of size, for example, are there in the group clinic arrangement? How do groups adjust to changes in the realm of medical practice, changes primarily medical but having also economic implications? What external conditions affect the organization of medical services? In this last category I would include developments in transportation and in technical equipment, availability of ancillary facilities, and the knowledge which the consumer has and employs in his consumption of medical care.

Influencing Factors

Expectations regarding the growth and importance of group arrangement of physician units have often been exaggerated, I believe, because of exaggerated notions about the economies of size in our society generally. The production or technological advantages are usually exhausted in the single plant. Since all of our big firms are multiplant, their size is not required by technological conditions and their size has vastly exceeded the technological economies that can be derived.

In the area of decision-making, often called managerial but more accurtely entrepreneurial, the firms in our economy are characterized by much decentralization. General Motors copes with its size by having more than twenty substantially autonomous divisions, each of which is internally characterized by a great deal of managerial decentralization. Only in this way can the problems of coordination in a big organization be handled.

Much evidence is readily available on the diversity of American industry and the range in size of its firms. In autos, firms range in size from a small, single-plant parts supplier with a handful of employees to any of the big three. The flexibility and resiliency of a relatively small firm has recently been demonstrated by American Motors. Many of you are closely aware of the range of size in the petroleum industry from small well operators and amazingly small refiners to the biggest firms. Other industries as shoes and apparel are characterized by these variations in size. The bigger firms tend to make the more highly standardized, staple products, whereas the smaller companies make the more varied stylish specialties. The latter commonly require a lot of quick decision making. But this is not compatible with the big organization that tends to become afflicted with a great deal of bureaucratic red tape. Hence, my introductory use of the quotations and their relevance to the medical field where decisions usually should be made by one man, often should be made immediately upon the completion of the examination and the ensuing diagnoses, and less commonly require the advice of one or two additional men, but only rarely that of a great number of consultants.

Genuine economies of size probably lie in the areas of finance and marketing. The former refers to the ability to obtain funds. Big firms are usually deemed better credit risks and so can borrow at lower interest rates than smaller firms. They also can usually float capital stock. The big firm, moreover, can obtain a greater volume of advertising per dollar of sales than the small firm can. But the marketing advantage is of no consequence in medicine; advertising is unethical. Ordinarily the credit of physicians is very good, though it may well be that a group has an advantage over an individual physician in obtaining capital.

It may also be argued that a number of physicians will use capital (technical) equipment more intensively—and therefore more efficiently—than a physician practicing alone. I am much impressed by the combined facts that groups often have their own laboratories and sometimes hospitals and that they are more common in small than in big communities. One must wonder how much the formation of the group was due to the absence otherwise of ancillary facilities and the need to join together—possibly in order to obtain the capital—to provide these facilities. Surely any study of group practice should strive to study the presence or absence of ancillary facilities as a factor obviating or requiring the group arrangement.

The presence or absence of a need for group arrangements can be appraised in part by a review of other advantages often said to be associated with this arrangement —personal, professional, and economic advantages to the physician and the patient. Consider the economic advantages first. If the provision of physicians' services through the group arrangement is more efficient than individual practice, the physicians' incomes can be higher while fees to the patient are lower because the business operates on a lower ratio of expenses to gross receipts. But does this happen? Convincing data do not exist. The aforementioned AMA study currently in progress has not asked the question I have in mind; but the ratio of ancillary personnel to physicians has been checked. Since it is higher in the bigger groups, overhead is greater, and it is very doubtful that expenses comprise a lower proportion of gross receipts than in other arrangements.

The question of quality of care belongs to the medical profession and is beyond the competence of an economist. Physician-patient relationships are inviolate in all ethical forms of medical practice. Personal considerations for the physician can be cared for in a variety of ways. A physician practicing as an individual can make a working agreement with one or more other physicians. Likewise he can share facilities with him and possibly accrue some economies thereby. Again so many alternatives are available that compulsion toward one form of practice or another seems quite untenable.

My interest in the combined facts of the group's providing its own ancillary facilities and being more common in smaller cities is related to an important characteristic of economic development. This development in turn is related to the future prospects for group practice. In general as the market grows, smaller independent specialists appear to provide the ancillary functions which are usually shed by the older, bigger firms. If the need to provide its own ancillary services was an important factor in the formation of a group practice, this factor will tend to disappear with the growth of the community. The group may well continue in practice for any number of other reasons. New groups are less likely to appear in such a community (or region) though they may appear in other areas reaching a size sufficient to sustain a group but not as yet big enough to develop specialist ancillaries.

Consumer Knowledge

A final consideration relates to the knowledge with which the patient consumes medical, or physician, services. I am generally not in sympathy with those who belittle the rationality of the American consumer, though I do believe that the consumer is often uninformed. The glaring illustration of this, I believe, lies in the credit area of consumption where the ignorant consumer is victimized by excessively high carrying charges, interest rates and loan fees. Here as in some other respects consumer economics is a much neglected part of the subject.

The chief difficulty in the medical area lies in the consumer's assuming he knows what specialist to visit as soon as he is conscious of a symptom. In the medical area, as elsewhere in the economy, specialization or the division of labor genuinely contributes to economy, to efficiency, if properly employed. There has been some talk, justified or not, of overbalance toward specialization in the field of medicine, much of it suggesting that the responsibility lies largely upon the medical profession. If such an overbalance exists, the consumer undoubtedly exerts an influence in his quite commendable zeal for

the highest quality of medical care. He often thinks that a specialist will give him the best therapy whether his ailment is serious or slight and whether or not he knows exactly what his ailment is.

In the automobile repair field one does not consult an automatic transmission specialist for a squeaky clutch. Nor would it seem highly appropriate for one to visit an orthopedic surgeon for a twitch in the back, or to see a neuro-surgeon for a headache. These statements are exaggerated, of course. Our consumers ordinarily exhibit better knowledge and understanding of the pursuit of medical care than these extreme illustrations suggest. But ordinarily the manifestation of a symptom should influence a patient to call upon a general practitioner or, as some consumers now appear to insist, to visit an internist. Much time and other expense can be wasted in calling upon a specialist who proves not to be the one trained to care for the ailment ultimately diagnosed, with the result that the medical and economic benefits of the division of labor are lost. If knowledge and understanding of the desirable approach to the acquisition of medical care are lacking, the provision of medical care through a group arrangement may be more efficient than under individual physician arrangements. In this respect it would seem that some positive, constructive, educational work could be performed by consumer groups. I regret to say that, in contrast, certain self-designated consumer groups indulge in diatribes on medical care costs which often distort the data and misrepresent the facts.

There are a number of relevant factors which unfortunately I've not managed to discuss in this brief talk. Review of referral practices may expose a great deal of useful information about what physicians are doing and about some patient habits as well. Nor have I been able to raise the problem about what might occur in group practice arrangements when there ought to be fewer doctor members or, because of the progress of medical care or some change in consumer demand, the combination of generalists and specialists ought to be revised within the group.

I have not examined at all the future influence of changes in transportation and communication and their effects possibly or urbanization. If anything, I suspect that urbanization, of which suburbanization is a facet, will proceed in the coming years. I gather that via the turnpike one can travel from Oklahoma City to Tulsa in an hour and a half or less. The day may not be very far off when Oklahoma City and Tulsa will comprise one greater metropolitan area. Under these circumstances I would expect the division of labor to continue to grow—in medicine and its allied areas. What this may bode for group practice I surely cannot foretell for there are many other factors whose future developments and even the direction of them are much less easy to anticipate—and for any we may very well in the very near future be proved wrong in our present expectations.

Summary

Very briefly I have throughout this talk referred to the diversity of arrangements in our economy and the ways in which economic forces in our society apply to the practice of medicine as well as to the supply and demand of other goods and services. A few facts were cited on the geographical distribution of physicians and groups of them in Oklahoma as well as on the extent of group practice in Oklahoma. Some reference was made to the relationship between the situation in Oklahoma and that in all of the United States as well as to the implications of this relationship. Analysis of the factors affecting the presence or absence, extension or contraction of group practice casts doubt upon many economies claimed for group practice, points to the importance of better consumer education, emphasizes, once again, the variety or arrangements available in our society, and urges that studies of the distribution and organization of physicians—and other agents and facilities—in the provision of medical care consider the many variables mentioned in this talk as well as others presently beyond my limited imagination.

PRESIDENT'S LETTER

Oklahoma received more than usual attention at the Interim Meeting at the American Medical Association Convention in Dallas, Texas on December 1-4, 1959.

The award received by Doctor Chesley M. Martin of Elgin, Oklahoma was of national interest. The reasons he received this award might be considered well by all of us as objectives in our lives as physicians and citizens—selflessness and dedication. Incidentally, a member of the Award Committee told me that Doctor Martin was not only the outstanding candidate, but that the presentation, as prepared by our Don Blair, was the most outstanding in the history of the thirteen years of the award.

The Southwestern Hospitality Suite, sponsored by the Oklahoma State Medical Association and the associations of our sister states, was an outstanding success. The barbecued buffalo from Oklahoma was one of the main reasons. Great credit is due our delegates and alternates, who served as a committee in its planning.

Clyde T. Baker M.D.

Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

News

Actions of AMA Clinical Meeting

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4 in Dallas.

Oklahoman Receives Honor

Doctor Chesley M. Martin of Elgin, Oklahoma was named as the 1959 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Doctor Martin, who has practiced in Elgin for the past 44 years, was the 13th recipient of the annual award and the first Oklahoman to be so honored.

Speaking at the Tuesday opening session of the House, Doctor Louis M. Orr of Orlando, Fla., AMA President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs and community life. Doctor Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

Total registration through Thursday, with half of the day of the meeting still remaining, had reached 4,727, including 2,742 physicians.

Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

Physician-Hospital Relations

The House received 12 resolutions on the

subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superceded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion and establishment of medical schools.

6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. Develop methods of getting well-qualified students to undertake the study of medicine.

8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the AMA. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

Miscellaneous Actions

In considering 44 resolutions and a large volume of annual, supplementary and special reports, the House also:

Learned that the AMA Board of Trustees has appointed a liaison committee to meet with a similar committee of the *American Osteopathic Association* to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of *pharmacies* or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the *cardiovascular system* in the AMA Journal;

Recommended that Association councils and committees, whenever feasible, hold their meetings in the remodeled *Chicago headquarters;*

Called for investigation of the need, desirability and feasibility of establishing a home for *aged and retired physicians;*

Commended *Doctor F. S. Crockett,* retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in *Nursing Homes* and Related Facilities;

Suggested that fees for consultative examinations under programs of the *Bureau of Old Age and Survivors Insurance* should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the *Veterans Administration,* urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the *Blue Shield* concept and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement on AMA relationship with Blue Shield plans;

Suggested that S.J. Res. 41, a bill which would institute a separate program of *international medical research,* be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for *Foreign Medical Graduates* but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that *medical schools* include in their curricula a course on the social, political and economic aspects of medicine;

Declared that the threat of *nuclear warfare* has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the AMA make available to school libraries *information and literature* showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of *aircraft crew members* should be made by doctors of medi-

cine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper *tetanus toxoid,* original and booster, and other immunizations as indicated from their physicians, and called on AMA members to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all *fluoroscopes and radiographic equipment*;

Approved the Speaker's proposal that the opening session of the House, at the *Interim Meeting,* be moved from Tuesday morning to Monday morning, with the reference committees meeting on Tuesday and the House reconvening on Wednesday afternoon;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the *Forand type of legislation;*

Urged state and local medical societies and individual physicians to implement the AMA program for recruitment of high-grade *medical students;*

Changed the title of the Section on Surgery, General and Abdominal, to the Section on *General Surgery;*

Accepted with appreciation a $2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of *Doctor Thomas G. Hull,* retiring secretary of the Council on Scientific Assembly, and

Reaffirmed the "Suggested Guides to Relations Between Medical Societies and *Voluntary Health Agencies,*" which were adopted at the December, 1957, meeting in Philadelphia.

At the Tuesday opening session, six state medical societies presented nearly $250,000 to the American Medical Education Foundation. The checks turned over to Doctor George F. Lull, president of AMEF, were: California, $156,562; Indiana, $35,570; New York, $19,546; Utah, $10,355; New Jersey, $10,000, and Arizona, $9,263.

Family Doctors Schedule Philadelphia Meeting

The American Academy of General Practice will hold its 12th Annual Scientific Assembly, March 21-24, 1960, in Philadelphia's Convention Hall. More than 4,000 family doctors and 3,000 residents, interns, exhibitors and wives will attend the four-day program highlighting recent progress in medicine and surgery. The Academy has more than 26,000 family doctor members and is the nation's second largest medical association.

The Philadelphia Assembly program lists 31 prominent medical educators who will discuss a variety of subjects ranging from arthritis and anemia to surgery, geriatrics and mental health. The doctors will also visit more than 100 scientific and 300 technical exhibits. Many of the scientific exhibits will relate directly to the scientific program. They have been carefully selected to answer questions posed by the doctor in active practice. All of the nation's major pharmaceutical firms will be represented in the technical exhibit area.

During the meeting, the doctors will have a chance to be on the other end of a stethoscope during physical examination sessions. More than 600 doctors took physical examinations at the last Academy meeting. Many learned, for the first time, that they needed immediate medical attention.

The scientific program will start at 1:30 p.m., Monday, March 21, and end at noon, Thursday, March 24. The Academy's policy-making Congress of Delegates will meet prior to the scientific sessions, at 2 p.m., Saturday, March 19. All sessions of the Congress and many social functions will be held in the Bellevue-Stratford hotel.

Wednesday evening, March 23, following induction ceremonies for Academy President-elect John Walsh, Sacramento, California, more than 2,000 guests will attend a reception and dance honoring President Fount Richardson, Fayetteville, Arkansas.

The Academy Assembly is this year combined with the Philadelphia Postgraduate Institute.

OSMA President Alfred T. Baker, M.D., Durant, is shown addressing Martin's followers as Doctor Martain, left foreground, and association Vice-President Charles Green, M.D., Lawton, wait their turns.

Doctor Martin Comes Home

Elgin Celebration Attended by 1200

Over twelve hundred grateful friends and patients staged a homecoming celebration on December 6 for Chesley M. Martin, M.D., newly-elected General Practitioner of the Year of the American Medical Association. The event, which took place in the school gymnasium of Doctor Martin's hometown of Elgin, was the climax of nearly a week of personal appearances and television interviews following his selection as the nation's typical family physician.

Mastermind of the hero's welcome was school superintendent Arthur Farrar, Ph.D., who also served as master of ceremonies for the testimonial-type program. Appearing as speakers were: Alfred T. Baker, M.D., Durant, President of the OSMA; Charles Green, M.D., Lawton, OSMA Vice-President; P. A. Becker, Lawton; Maxine Reiff, M.D., Oklahoma City, and William Saupitty, Elgin, leader of the Comanche Tribe.

One of the highlights of the celebration occurred when William Saupitty, Leader of the Comanches, made Doctor Martin an honorary Comanche Chief.

DETAILMEN HONOR DOCTOR MARTIN

The nation's family doctor was doubly honored in Dallas when he received the Medical Service Society of America's Plaque and Key Award from Charles E. Buell, M.S.S.A. President and Dearborn, Michigan representative of Eaton Laboratories.

AAGP Meeting Set For February

The Twelfth Annual Meeting of the Oklahoma AAGP will be held at the Tulsa Hotel, February 15 and 16, 1960. Program Chairman, Marshall O. Hart, M.D., Tulsa, recently announced the completion of an outstanding scientific and social program which is printed below. Further information may be obtained by writing to Doctor Hart, 1228 South Boulder, Tulsa, Oklahoma.

TWELFTH ANNUAL MEETING PROGRAM

Monday, February 15, 1960

8:00 a.m.—Registration

8:55 a.m.—Address of Welcome, Mayor Maxwell, Tulsa

9:00 a.m.—Keith Hammond, M.D., Paoli, Indiana—"Factors Involved in Rational Treatment of U R I in Children"

9:30 a.m.—Benjamin Felson, M.D., Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio—"Some Fundamentals in Chest Roentgenology"

10:00 a.m.—Visit Exhibitors

11:00 a.m.—James Kelley, M.D., Tulsa, Oklahoma—"Plastic Surgery"

11:30 a.m.—Isadore Dyer, M.D., Tulane University, New Orleans, Louisiana—"Abruptio Placenta, Present Day Concept of Treatment"

12:00 noon—Roundtable Luncheon

1:30 p.m.—Carlo Scuderi, M.D., Chicago, Illinois—"Common Feet Problems"

2:15 p.m.—A. S. Ridolfo, M.D., Indianapolis, Indiana—"Classification and Treatment of Diabetes Whether Orally or Parenterally"

3:00 p.m.—Visit Exhibitors

3:30 p.m.—W. D. Snively, M.D., Medical Director, Mead Johnson, Evansville, Indiana—"Management of Fluid Balance in Obstruction of the Large Bowel"

4:00 p.m.—Benjamin Felson, M.D.—"Some Roentgen Aspects of the Acute Abdomen"

6:30 p.m.—Social Hour

7:30 p.m.—Banquet—Dinner Music by Honey Hudgens (Miss Hospitality of Tulsa)
Speaker will be Fount Richardson, M.D., President of the American Academy of General Practice, Fayetteville, Arkansas—"The Doctor and Politics"
Entertainment by the Student Entertainers, State University, Stillwater, Oklahoma

Tuesday, February 16, 1960

8:00 a.m.—Annual Business Meeting

10:00 a.m.—A. S. Ridolfo, M.D.—"Complication of Diabetes, Including Management During Obstetrical and Surgical Emergencies."

10:30 a.m.—W. D. Snively, M.D.—(Continued) "Management of Fluid Balance in Obstruction of the Large Bowel"

11:00 a.m.—Keith Hammond, M.D.—"Pediatric Errors"

11:30 a.m.—Visit Exhibitors

12:00 noon—Roundtable Luncheon

1:45 p.m.—Carlo Scuderi, M.D.—(Continued) "Common Feet Problems"

2:30 p.m.—Visit Exhibitors

3:30 p.m.—Isadore Dyer, M.D.—"Management of Emergencies in the Third Stage of Labor and Immediate Puerperium"

4:00 p.m.—A. N. Taylor, Ph.D., Associate Dean, University of Oklahoma Medical Center, Oklahoma City, Oklahoma — "Meducation — A 1960 Profile"

4:30 p.m.—Drawing for Major Prize

LADIES' ENTERTAINMENT

Monday, February 15, 1960

Luncheonette, Sky Terrace Room, Tulsa Club

Style Show—Streets Clothiers

AMA, AHA Pledge Health Help for the Needy

The Boards of Trustees of the American Hospital Association and the American Medical Association, in a joint resolution of December 6, announced they will mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons — especially the aged needy.

The resolution made it clear that both organizations will stimulate their state and local components to work with local government toward adequate financing of high quality health care for the needy supported by all community resources and necessary tax funds.

The resolution stated that provision of health care to "the indigent or near indigent is primarily a community responsibility," and made these points:

One: The Boards of Trustees recognize the effective medical care programs for needy persons already established in some states and local communities, but have taken this joint action because of their conviction that such programs deserve increased support and stimulation.

Two: Such proposals as the Forand bill are not designed especially to assist the needy, since they apply to all social security beneficiaries and exclude the majority of needy persons who are not eligible for social security benefits. (Under the Forand bill, sponsored by U. S. Representative Aime Forand [D.-R.I.], some 16 million persons eligible for Social Security benefits—mostly those over 65—would be entitled to receive hospital, surgical and nursing home treatment under a program run by the Federal government. Both the American Hospital Association and the American Medical Association oppose the bill.)

Commenting on the passage of the joint resolution, Doctor Russell A. Nelson, president of the American Hospital Association and director of the Johns Hopkins Hospital, Baltimore, said: "Full payment by states and local communities of the actual costs of care for the indigent and those of low income is still a rarity, although the responsibility for such payment is acknowledged.

"Inadequate payment for high-cost care means that the costs of the care of the needy must be met by the paying patient, by cutting back needed expansion of hospital services, or by payment of insufficient salaries to hospital employees," Doctor Nelson said.

Doctor Louis M. Orr of Orlando, Florida, president of the American Medical Association, said: "The responsibility for taking care of the old person rests primarily with his family. If the family cannot fulfill this responsibility, then it passes to the community, and then to the state.

"We will do everything in our power to encourage local and state governments to fulfill this responsibility.

"Forand-type legislation would reduce the quality of medical care in this country. Such legislation is political medicine."

Text of Resolution

As approved by the Board of Trustees of the American Hospital Association and the Board of Trustees of the American Medical Association, the resolution is as follows:

"WHEREAS The provision of health care to the indigent or near indigent is primarily a community responsibility, and

WHEREAS This responsibility is not being met in many areas because of inadequate financing or poorly planned health care programs, and

WHEREAS Such proposals as HR.4700 (Forand Bill) are not designed especially to assist the needy, since they apply to all Social Security beneficiaries and exclude the majority of needy persons who are not eligible for Social Security benefits, therefore be it

RESOLVED That the Boards of Trustees of the American Hospital Association and the American Medical Association do hereby resolve to mobilize their full resources to accelerate the development of adequately financed health care programs for needy

persons—especially the aged needy—and to stimulate our state and local components to work with local government toward adequate financing of high quality health care for the needy, supported by all available community resources and necessary tax funds. The Boards of Trustees recognize the effective medical care programs for needy persons already established in some states and local communities, but have taken this joint action because of their conviction that these programs deserve increased support and stimulation."

School Health Plan Outlined by Pediatricians

Recommending the employment of private physicians as important members of the school health team, the Committee on School Health of the American Academy of Pediatrics has outlined a health program for school age children.

They advocated the arrangement to be on a part-time basis to bring private physicians into the program further to encourage the doctor's office as the place for detailed examination and treatment.

"Such immunization procedures as are indicated by good pediatric practice should insofar as possible, be done by the patient's private physician or local health department," the Academy committee advised.

Immunizations against diphtheria, tetanus, pertusis, poliomyelitis, smallpox, and others such as typhoid which may be indicated by local conditions, are generally advised by the Committee on Control of Infectious Diseases of the American Academy of Pediatrics, the doctors mentioned, and said that the schools should not take responsibility for performing the actual immunizations.

Describing the function of the school physician, the Academy committee said that he is a health adviser instead of a source of medical care. He is a liaison officer between schools, physicians and health agencies, he advises the school staff on medical matters, he analyzes, with the nurse, the information she has gathered about pupils and their families, and he advises parents and children as to the facilities which exist for solving their medical problems.

"He should not replace or substitute for the child's own physician or other community health service," the pediatricians cautioned.

"The school health team should strive for the cooperation of the local physicians. In turn, the local medical societies and private physicians should cooperate and collaborate with the program," the committee wrote.

They recommended that the school health team employ private physicians part time and give pre-service training courses for them and the entire staff. The team should use standard forms to record examinations and progress, and continuously remind local physicians of the purpose and functions of the school health service. They should make available to private physicians the results of any examinations and appraisals made in the school.

The committee suggested that the medical examination be used as an opportunity to promote preventive medicine, health improvement and health education, rather than solely for the detection of health impairments, and said such a conference should take place in the office of the child's physician.

It is important that health education be integrated into such areas as language, history, science, physical education and social studies, the committee held. Such integration cannot be accomplished unless the teacher has a background of health education or has assistance from the group cooperating in the school health program. It is likewise important that courses in health education be established.

"If the teaching ability of the professional educators can be combined with the medical knowledge and practical experience of the practicing physician and of the public health

physician, children will be better instructed in matters of health and disease," the pediatricians held.

The pediatricians advocated teamwork by private physicians, school physicians, parents, teachers and nurses, and reported:

"The major purpose of a school health program is to maintain, improve and promote the health of the school age child. The program should include adequate supervision of the physical, mental, emotional and social aspects of school life. It also includes planning the course content and instruction in nutrition and health education, including accident prevention, recreation and physical education."

To carry out these objectives, the pediatricians said three services are needed:

1. Health Appraisal. Routine, regular physical examinations, preferably prior to entrance to school, during the intermediate grades, at entrance to secondary school, and before completion of secondary school.

2. Follow-up. It is a waste of time and effort to find the child with a health problem unless something is done about it. Something must be done to insure that the child is placed under adequate medical supervision for the correction of any remediable abnormality found at the time of the examination, or to obtain medical advice as to his adjustment to education in cases where the defect cannot be remedied.

3. Parent Education and Parent Counseling. An important function of the school health program is to educate and counsel the parents in discharging the responsibility that the child's health rests with his parents. It is important to get the co-operation of the parents and to motivate them to heed their physician's advice in obtaining the necessary medical care.

The pediatricians outlined details of the parts each member of the team plays. Parents should be alert to notice changes in their children's appearance or actions which suggest need for medical advice, they counseled.

Teachers may be prepared through their interests and education to observe pupils for deviations from normal appearance and behavior.

"Not all teachers are adequately prepared or equipped to assume this responsibility," the report said. "Some teachers are not good observers. Their many pedagogic duties are naturally their major interest. In-service training for their part in the school health program is essential."

The committee recommended that the teacher transmit her impressions to the physician or school nurse and to the parents only if there is no intermediate medical personnel in the school. "If she consults directly with the parent, she should be very careful not to make a diagnosis, which, if wrong, could be damaging to both the parents and child. Instead, she should point out apparent functional deviations and recommend medical attention. Her exact procedure will depend on the individual case, but will always call for tact and discrimination."

The committee praises the importance of the teacher, and that of the school nurse. The nurse is at the center of activities and has direct relationships with teachers, physicians, health officials and parents. The nurse helps train teachers in observation and screening. She assists the school physician, prepares records and medical histories, and is a counselor and friend to the parent. Her position in relation to the community was emphasized:

"She relates the health services in schools to the work of other community health services, and many times she is the interpreter or coordinator of health activities within the school. She has an important role in interpreting handicapped children to the school staff, and she works with guidance, psychologic and special education services on their behalf.

"Much of her work can be accomplished through the school health council; on it the nurse is usually the motivating and coordinating force."

New members of the Tulsa County Medical Society honored at the annual indoctrination dinner on December 8th at Tulsa are: Left to right, seated—Kenneth L. Duncan, M.D.; C. Frank Knox, Jr., M.D.; James W. Kelley, M.D., Society President; David C. Clemans, M.D., Skiatook; Robert L. Lubin, M.D., Chairman of the Medical Precepts Committee; Francis W. Pruitt, M.D., and Dwane B. Minor, M.D. Standing, left to right—Nathan A. Cohen, M.D.; Richard A. Liebendorfer, M.D.; Kenneth L. Knuth, M.D.; John E. Kauth, M.D.; William L. Harris, M.D.; Joe Burge, M.D.; and Jack E. Hale, M.D. Not present when photograph was made were Jack W. Newport, M.D.; Hobart C. Sanders, M.D., and Duane E. Brothers, M.D.

Tulsa County Society Welcomes New Members

Fifteen new doctors who entered practice in Tulsa County during 1959 were formally welcomed into the Tulsa County Medical Society last month.

The occasion was the Society's Annual Indoctrination Dinner for New Members held at the Mayo Hotel on Tuesday, December 8, 1959.

The newcomers heard lectures on medical ethics, local customs of practice, malpractice prevention and defense, current federal medical legislation, the doctor and the press, and financial aspects of private practice.

Guest speakers included Mr. Richard M. Nelson, Field Representative for the American Medical Association, Chicago, Illinois; Mr. Truman B. Rucker, Tulsa attorney and legal counsel for the Tulsa County Medical Society; Walter F. Sethney, M.D., Chairman of the Ethics Committee; John E. McDonald, M.D., Chairman of the Legislative Committee; Marshall O. Hart, M.D., Chairman of the Medical Advisory Committee; James W. Kelley, M.D., President; and Mr. Jack Spears, Executive Secretary.

The program, an annual event first begun in 1954, was under the direction of the Society's Medical Precepts Committee. Robert I. Lubin, M.D., Chairman, presided.

New doctors honored at the dinner included:

Joe Burge, M.D., thoracic surgeon; Duane E. Brothers, M.D., anesthesiologist; David C. Clemans, M.D., general practitioner, Skiatook; Nathan A. Cohen, M.D., pathologist; Kenneth C. Duncan, M.D., neurologist; Jack E. Hale, M.D., pathologist; William L. Harris, M.D., general practitioner; John E. Kauth, M.D., radiologist; Kenneth L. Knuth, M.D., radiologist; C. Frank Knox, Jr., M.D., psychiatrist;

Richard A. Liebendorfer, M.D., internal medicine; Dwane B. Minor, M.D., dermatologist; Jack W. Newport, M.D., orthopedic surgeon; Hobart C. Sanders, M.D., gynecologist and obstetrician; and Francis W. Pruitt, M.D., director of postgraduate education at Hillcrest Medical Center.

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1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

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to school...
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in a week after
recurrent episode[1]

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resumed after 4 days
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Health Problems Discussed on New Radio Series

Script for a new radio series concerning family health problems are discussed by Doctor Gerald Dorman (right) of the American Medical Association, Doctor Benjamin W. Carey (left), of Lederle Laboratories, and American Broadcasting Company's John Daly. The three organizations are cooperating to present the public service series, called "Highroad to Health." It is being carried nationally by the ABC radio network. Each program in the weekly series presents in dramatic form a health problem commonly encountered by American families, followed by a discussion of the problem by a distinguished guest physician. Doctor Dorman is Co-Chairman of the Physcian's Advisory Committee on Radio and TV of the AMA. Doctor Carey is medical director of American Cyanamid Company's Lederle Laboratories and Mr. Daly, television and radio personality, ABC vice president for public affairs. Local program listings or ABC stations should be consulted for exact broadcast schedules for "Highroad to Health."

PARTICIPATE IN YOUR ANNUAL MEETING!

HOW? By preparing a SCIENTIFIC EXHIBIT or by documenting a BIZARRE CASE as described on pages 52, 53.

WHEN? Applications must be received prior to March 1, 1960. The meeting will be held in Oklahoma City on May 2, 3 and 4.

WHY? It will be the best meeting ever . . . a real opportunity to share your experiences with over half of the OSMA membership.

Texas University Announces Medical Cruise

The University of Texas Postgraduate School of Medicine has announced plans for the Annual Texas Medical Cruise to the Caribbean, May 6, to May 19th, 1960.

Faculty for the fourteen day cruise will be Alfred E. Leiser, M.D., Clinical Instructor in Medicine, Baylor University College of Medicine and Clinical Assistant Professor of Medicine, University of Texas Postgraduate School of Medicine, Houston, Texas; L. Maxwell Lockie, M.D., Professor and Head of the Department of Therapeutics, University of Buffalo School of Medicine, Buffalo, New York; Jarrell E. Miller, M.D., Clinical Professor of Radiology, University of Texas Southwestern Medical School, Dallas; and Fred M. Taylor, M.D., Associate Professor of Pediatrics, Baylor University College of Medicine, Houston, Texas.

The cruise will depart from New Orleans on May 6 and return to New Orleans on the 19th. Ports of call will include: Havana, Cap Hatien, Port-Au-Prince, Montego Bay and Grand Cayman.

The itinerary will allow 25 hours of Category I teaching credit for physicians desiring AAGP credit.

OB-GYN Examinations

Examinations (Part II), oral and clinical will be held in Chicago at the Edgewater Beach Hotel from May 11 through 16, 1960. Details available from Robert L. Faulkner, M.D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

REQUEST FOR JOURNALS

The Journal of the Oklahoma State Medical Association would appreciate receiving copies of the 1959 June and September issues of THE JOURNAL. Please mail to P.O. Box 9696, Oklahoma City, Oklahoma.

Have You Heard?

PAT FITE, SR., M.D., Muskogee, attended the Western Surgical Meeting in Colorado Springs during November.

RALPH A. MCGILL, M.D., Tulsa surgeon, was recently presented a plaque recognizing his twenty years' service as member and chairman of the Hillcrest Medical Center's board of governors.

FRANCIS E. SMITH, M.D., formerly of Kingfisher, has recently opened a new clinic in Norman, located at Comanche and Lahoma streets.

R. L. CURRIE, M.D., Stilwell, and R. H. MAYES, M.D., Duncan, have been appointed County Superintendents of Health of their respective counties, Adair and Jefferson.

ROBERT C. LAWSON, M.D., Oklahoma City, has been appointed to the Board of State Governors of the American Diabetes Association. Purpose of the Board is to stimulate interest in diabetes and related conditions, as well as facilitate coordination of activities in this field.

J. B. HOLLIS, M.D., Mangum, has been appointed Chairman of the National Rehabilitation Committee of the American Legion. Doctor Hollis, who has served in various capacities in the Legion for over forty years, will be in charge of the benefit program on a national scale.

WILLIAM L. BYNUM, M.D., has opened offices in the Barnes Building in Muskogee where he will specialize in Obstetrics and Gynecology. A graduate from the University of Arkansas Medical School, Doctor Bynum has completed a year's residency at the Arkansas Medical Center in Little Rock.

Have something to exhibit

If so, you should apply now for space at the 1960 meeting of your association. Scientific Exhibits will again play a major role . . . so why not prepare a graphic presentation of your work and share it with the 700 physicians who will attend the state's largest medical meeting? A research or clinical project may be shown as an individual exhibit, or you may present a single case in the "Klinical Kaleidoscope" section.

Research or clinical project

Perhaps you have done some original research, undertaken some experimental work, or simply drawn some conclusions based upon a series of interesting cases. Then you would be eligible to apply for an exhibit booth of your own in the Scientific Exhibit Section. A subject which has a special visual interest would be particularly suitable . . . and it need not be large—just stimulating!

Bizarre case

All of us have encountered a unique case which is worth talking about. If you have a well-documented one which you would like to share with others, toss your hat in the ring today by completing the application on the opposite page. The "Klinical Kaleidoscope" section will be a varied selection of bizarre cases, each presented with one to five x-rays or illustrations and accompanied by a very brief abstract of the clinical course.

O.S.M.A. ANNUAL MEETING

municipal auditorium · oklahoma ci

may 2·3·4, 1960

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

54th Annual Meeting

OKLAHOMA STATE MEDICAL ASSOCIATION

Municipal Auditorium — Oklahoma City — May 2, 3, 4, 1960

1. **NAME AND ADDRESS OF APPLICANT:**

2. **TITLE OF EXHIBIT:**

3. **INDIVIDUAL BOOTH?** ☐ **"KLINICAL KALEIDOSCOPE" SECTION?** ☐

4. **SPACE REQUIRED:**

   A. **BOOTH: Indicate width in multiples of eight feet** _____

   (All booths will be 6 feet in depth)

   B. **"KLINICAL KALEIDOSCOPE": Indicate square footage:**

   Wall-type display _____ **Table top** _____

5. A. **GENERAL DESCRIPTION:**

   B. **MATERIAL TO BE SHOWN (Subject matter):**

   C. **METHOD OF PRESENTATION (x-ray, photos, graphs, models, etc.):**

6. **PREVIOUS SHOWINGS**

ACT NOW — SPACE IS LIMITED

Applications Must Be Received Prior to March 1, 1960

Oklahoma State Medical Association • Box 9696 • Oklahoma City

Auxiliary News

Safe New Year

What more appropriate way can be found to start the new year than by personal participation in making our world a safer place in which to live? Startling daily statistics in our public and private lives keep us constantly aware of the need to do "something." Our National Safety Chairman interprets our Safety Program as being three dimensional: you, your family, and your community.

Accident Prone?

Obviously, Auxiliary members can begin with evaluation of home safety. The phrase "accident-prone," which has been over-used during the last few years might in many cases give us cause for pause. If we apply the description rather loosely to one of our own children or to a family member, can we objectively say that our own negligence or carelessness is never contributory?

Opportunity Unlimited

Safety Chairmen perform one of our most important functions. Her realm is unlimited. Cooperation of members must be constructive on a community basis. After evaluating your own town or city, the Safety Committee can present its findings to your Auxiliary for specific action. In few fields can so much be accomplished. Include, in addition to specific home safety improvements, your schools, your churches, your public buildings, your traffic problems. Achieve some good public relations, too, by working with various groups in your city. Find interested allies in your local Safety Council, Civil Defense, your city or county Safety Commissioners.

In our effort to combat legislation and problems of aging, make a survey of Safety angles involved. Are rest homes in your area safe? Are county home facilities adequate from a safety angle? Do your Golden Age Clubs have material and instruction for driving and pedestrian safety?

Safety Goals—Practical Insurance

Our goals include educating each car-owner to the value of installing seat belts—and using them; educating our buying public to secure safety features as standard equipment for all cars; and by encouraging family car-owners to install safety features designed for the protection of their children. (Especially important is the follow-through on the last suggestion: teach small children good "car manners" as an intelligent approach to discipline and safety.)

Highway safety can include safe driver education programs for all drivers; periodic re-examination for drivers' licenses; education on chemical tests for intoxication; and factors in pedestrian safety and bicycle safety instruction.

Greater home and farm safety presents an inexhaustible array of material; particularly stressed is the establishment of poison control centers. (Every year over 1,000 Americans, largely children, die of accidental poisoning.)

We hope that as you have been reading, you have already focused a challenging eye upon some subject very close to yourself and your community. Your "individual responsibility" can be its effective best in promoting Safety to the utmost. If you need help in any way, your State Safety Chairman, Mrs. Floyd Bartheld, 530 East Creek, McAlester, is waiting to hear from you.

We wish for you a Safe New Year!

What's Your Hobby, Doctor?

The DOCTOR'S HOBBY SHOW has become one of the outstanding attractions at the OSMA ANNUAL MEETING. A project of the Woman's Auxiliary, the show offers physicians an excellent opportunity to display the products of their leisure time. If you have a hobby, don't keep it a secret . . . Show your colleagues what you can do . . . APPLY NOW!

Doctor's Hobby Show

O.S.M.A. Annual Meeting

Municipal Auditorium

Oklahoma City

MAY 2, 3, 4, 1960

Application For Hobby Show Space

54th ANNUAL MEETING

OKLAHOMA STATE MEDICAL ASSOCIATION

DESCRIBE EXHIBIT, including information as to size, shape and value (insurance is provided):

IMPORTANT: Deliver Exhibit to Zebra Room, Municipal Auditorium by noon, May 1. Your Exhibit will be personally attended and insured at all times. It must be picked up by noon, May 4, when management responsibility ends.

MAIL THIS FORM TODAY!

State Chairman—Mrs. William R. R. Loney
2440 E. 26th Place
Tulsa 14, Oklahoma

State Co-Chairman—Mrs. Harrell C. Dodson, Jr.
1108 N.E. 42nd Street
Oklahoma City, Oklahoma

Army Needs Doctors

The Surgeon General of the United States Army has announced the need for Doctors of Medicine for assignment to U. S. Army Medical facilities throughout the world.

Doctors who specialize in all branches of the Medical profession, with the exception of Pediatricians, Anesthesiologists, and Ophthalmologists are encouraged to apply for active duty with the U. S. Army. Applicants, upon acceptance, will be called to active duty for three years or they may volunteer for indefinite tours beginning in April of 1960.

Grades of appointees will be determined by number of years of participation in professional activities. Medical school and internship will be counted both for pay and for determining initial grade of applicant.

For further details and applications, interested Doctors in Arkansas, Louisiana and Oklahoma should contact Lt. Col. W. H. Dickerson, Headquarters, Oklahoma Sector Command, XIX U. S. Army Corps (Reserve), 1101 N. Broadway, Oklahoma City, Oklahoma, Telephone: CEntral 5-4552.

College of Surgeons to Hold Colorado Meeting

Surgeons and related medical personnel are invited to attend the three-day Sectional Meeting of the American College of Surgeons in Colorado Springs, Colorado, March 21 through 23, 1960. Headquarters will be The Broadmoor Hotel.

The program will include scientific reports on topics of current concern such as management of the injured hand, treatment of duodenal ulcer, appendicitis, treatment of neck fractures, surgical convalescence, and cancer and pregnancy. Symposiums on injuries, cancer and hospital infections will be presented. Also, selected medical motion pictures and cine clinic films from the 1959 Clinical Congress will be shown.

Wednesday, March 23, Doctor Paul R. Hawley, Chicago, The Director, American College of Surgeons, will be the speaker at The College dinner. The subject of his talk will be, "The Epidemiology of An American Legend."

Coming Meetings

UNIVERSITY OF OKLAHOMA MEDICAL CENTER
POSTGRADUATE PROGRAM*
Individual Postgraduate Courses

BASIC ELECTROCARDIOGRAPHY — February 29 through March 5.

OPTHALMOLOGY-OTOLARYNGOLOGY SYMPOSIUM—March 3 and 4.

OBSTETRICS-GYNECOLOGY SYMPOSIUM—March 5.

ADRENAL STEROIDS—March 24, 25, and 26. (Third Oklahoma Colloquy on advances in Medicine.)

ORTHOPEDIC SYMPOSIUM—May 13 and 14.

CARCINOMA OF THE SKIN—April 22 and 23. (Sixth Annual Combined Surgery, Radiology, Pathology Symposium.)

OKLAHOMA ASSSOCIATION OF HOUSE STAFF PHYSICIANS—May 6.

PEDIATRIC NEUROLOGY—May 12 and 13. This symposium to be held in conjunction with the Wednesday Short Course on May 11.

SERIAL POSTGRADUATE COURSE

Postgraduate Division

Oklahoma City, Oklahoma
1959-1960

Wednesday Short Courses
3:30 to 8:30 p.m.

Jan. 13	Carl Puckett Memorial Lecture and Infectious Diseases Symposium Guest Lecturer: William Tucker, M.D., Washington, D.C.
Feb. 10	Rehabilitation of the Cardiac Patient
Mar. 9	C. B. Taylor Lectureship and Urology Symposium—Guest Lecturer to be announced
Apr. 13	Anesthesia for the Part-time Anesthetist
May 11	Neurological Diseases in Childhood
June 8	Surgery

*Further information may be obtained from the Office of Postgraduate Education, University of Oklahoma School of Medicine, 801 N.E. 13th Street, Oklahoma City, Oklahoma.

OKLAHOMA CHAPTER
AMERICAN ACADEMY OF GENERAL PRACTICE
February 15-16, 1960 — **Tulsa Hotel**
Tulsa, Oklahoma

The 12th Annual Meeting of the Oklahoma Chapter of the American Academy of General Practice will be held at the Tulsa Hotel, February 15-16, 1960, in Tulsa. Complete program on page 43.

SCOTT AND WHITE CLINIC
EIGHTH ANNUAL POSTGRADUATE CONFERENCE
March 6, 7, 8, 1960 — **Temple, Texas**

This course, Current Topics in Medicine and Surgery, will be presented by Scott, Sherwood and Brindley Foundation and the University of Texas Postgraduate School of Medicine on March 6, 7, 8, 1960. Registration fee is $25.00 and the course is approved for 20 hours credit by AAPG. Further information is available by writing to Publications Office, Scott and White Clinic, Temple, Texas.

EIGHTH POSTGRADUATE COURSE
IN
DIABETES AND BASIC METABOLIC PROBLEMS
January 20, 21, 22, 1960 — **Ambassador Hotel**
Los Angeles, California

The Eighth Postgraduate Course in Diabetes and Basic Metabolic Problems will be offered by the American Diabetes Association, January 20, 21, 22, 1960 at the Ambassador Hotel in Los Angeles. The course is accepted for 18 hours credit, Category II, by the American Academy of General Practice. Detailed information is available by writing to American Diabetes Association, Inc., 1 East 45th Street, New York 17, New York.

AMERICAN COLLEGE OF ALLERGISTS
Graduate Instructional Course and Annual Congress
February 28-March 4, 1960 — **The Americana Hotel**
Bal Harbor
Miami Beach, Florida

The American College of Allergists will hold a Graduate Instructional Course and Annual Congress February 28 to March 4, 1960 at the Americana Hotel, Bal Harbor, Miami Beach, Florida. For further information, contact John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colorado.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY
March 7-10, 1960 — **Roosevelt Hotel**
New Orleans, Louisiana

The twenty-third annual meeting of The New Orleans Graduate Medical Assembly will be held March 7-10, 1960 in New Orleans. Complete details may be obtained by writing to Mannie D. Paine, Jr., M.D., Secretary, The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Deaths

Shade Durrett Neely, M.D.
1897-1959

Shade Durrett Neely, M.D., a practicing physician in Muskogee since 1922, died at his home November 19, 1959.

Born in Charleston, Mississippi on July 1, 1897, Doctor Neely graduated from the University of Oklahoma School of Medicine in 1920. After postgraduate work in Baltimore and New York City he established his practice in Muskogee where he specialized in urology.

Active in the Medical Profession for many years, Doctor Neely was a past president of the East Central Oklahoma Medical Society and at one time served as Councilor from District IX of the Oklahoma State Medical Association.

In addition to his work in the medical profession, he was active in the Masonic Lodge, having served in various capacities in Oklahoma and was an honorary member of the Masonic orders in Kansas, Texas, Arkansas, Indiana and Mississippi.

Samuel C. Rutherford, M.D.
1869-1959

Samuel C. Rutherford, M.D., 90-year-old Locust Grove physician, died in Pryor, November 13, 1959.

Born in 1869 at West Fork, Arkansas, Doctor Rutherford graduated from the University of Arkansas School of Medicine in 1901. Practicing first in Chouteau, Indian Territory, then at Wagoner, he came to Locust Grove in 1924 where he had practiced since.

Doctor Rutherford was honored by the Oklahoma State Medical Association in 1950 when he was presented with a Life Membership in recognition of his years of service to the medical profession.

Henry A. Ellis, M.D.
1876-1959

Henry A. Ellis, M.D., 84-year-old Kiowa physician, died November 13, 1959 in McAlester.

A native of Lidell, Mississippi, Doctor Ellis graduated from the College of Physicians and Surgeons in Dallas in 1905. After practicing in Mississippi for a short while, he came to the Chickasaw nation in Indian Territory, settling near Tishomingo, later moving to a community near Coalgate. Since 1914, he has maintained offices in Savanah, Kiowa and Pittsburg.

In 1952, Doctor Ellis was honored for his years of service to the medical profession when the Oklahoma State Medical Association presented him with a Life Membership.

25 YEARS AGO

Articles published in *The Journal* of the Oklahoma State Medical Association, January, 1935.

EDITORIAL
PUBLIC POLICY AND LEGISLATION IN 1935

There never has been a time since statehood when organized medicine in Oklahoma was in a more advantageous position to accomplish great good for the people in the state than this year, 1935.

We have come through the past four years with our "heads up" and our position well defined, notwithstanding the most serious opposition of the administration, this including the Board of Regents of the University. Even the Medical School has had to suffer from petty politics in dividing the administration of the University Hospital, thereby creating a spirit of unrest and uncertainty from the staff to the janitor, but the members of the medical profession connected with the school have stood fast and brought the institution through with no loss in its scholastic classification and the University Hospital still maintains its standardization. Post-graduate medical teaching has been carried on by the State Medical Association after the Board of Regents passed a resolution opening these courses to the cults, making it impossible for organized medicine to go on with this important phase of medical education with the aid of the University.

So much for our troubles and accomplishments during the past four years. Now let us look forward to the possibilities of 1935, under a state administration headed by a man of sound reasoning, who has indicated that he will favor any measure that will protect the people of this state and forward an intelligent program in the prevention and treatment of disease.

The legislative committee of this association has been active for several months; they have given careful consideration to many proposed bills affecting the medical profession and the health and safety of our people.

The crippled children's law must be changed to meet present conditions; a basic science law will do much to eliminate the unprepared candidate to practice the healing art in any of its branches; the rescinding of the resolution by the Board of Regents opening post-graduate medical teaching to the cults; the appointment of a doctor of medicine on the Board of Regents of the University; the protection of doctors and hospital fees in cases of automobile accidents, and many other items of legislation and policy will be under consideration.

Now comes the important point of this editorial—every member of the Oklahoma State Medical Association must accept his individual responsibility and use his influence to bring about a proper solution of these problems. If each physician who does the family practice for a member of the legislature would let him know his attitude toward these important questions there would be no doubt as to the accomplishment of this entire program. This is very little to expect from the individual doctor and as the legislature will be in session when you read this, let me suggest that you contact your senator or representative at once and let us take advantage of an intelligent administration to have enacted a set of intelligent laws, thereby promoting the health and happiness of the people for whom we are responsible.

NEWS OF THE COUNTY MEDICAL SOCIETIES

ALFALFA-WOODS County Medical Societies held their annual meeting for election of officers for 1935 and the following were elected:

Alfalfa County

President—J. P. Bishop, Aline.
Vice-President—Z. J. Clark, Cherokee.
Secretary—L. T. Lancaster, Cherokee.

Woods County

President—I. F. Stephenson, Alva.
Vice-President—C. A. Tracerse, Alva.
Secretary—O. E. Templin, Alva (re-elected).
Delegate—D. B. Ensor, Hopeton.

Thirty six crippled children were examined at the meeting by Doctors John Day, Supply; W. K. West and Harry Wilkins both of Oklahoma City.

Book Review

COLD INJURY, GROUND TYPE, Office of the Surgeon General, Department of the Army, U. S. Printing Office, Washington, D.C., 1958, pp. 570.

In the Southwest cold injury is uncommon. This volume is, to the reviewer's knowledge, the most complete treatise available on this subject. It is of historical and clinical importance, and should be available for all physicians engaged in general medical and surgical practice. Tissue damage due to cold at altitude, at ground level, in the tropics, and that associated with moisture with their pathogenesis, diagnosis, treatment, and epidemiology are described in separate sections. Care of the feet and their protection is emphasized. In the event of a mass disaster in the winter, the lessons learned and described can be beneficially applied to civilian populations and individuals.—*John A. Schilling, M.D.*

PHYSICIAN PLACEMENT

Dermatology

Thomas E. Slimp, M.D., 323 West Livingston Place, Metairie, Louisiana, age 42, married, Syracuse Medical School, 1950, board certified January 1, 1960. No military obligations, available January 1, 1960.

Gordon Harold Ekblad, M.D., Field Medical Service School, Camp Pendleton, California, 53, married, University of Minnesota, 1930, available January 1960.

General Practice

Johnny Bill Delashaw, U.S.P.H.S. Hospital, Wyman Park Drive and 31st Street, Baltimore 11, Maryland, age 27, married, University of Texas Medical Branch, 1959, available July 1960.

D. H. Bessesen, M.D., Grand Canyon Hospital, Grand Canyon, Arizona, age 61, married, University of Minnesota, interested University Health Service, available October 1, 1959.

Sherman Allen Hope, M.D., 1105 Yale Ave., Panama City, Florida, PO 3-6656, age 27, married, University of Oklahoma School of Medicine, 1957, available July 1960.

Paul J. Vega, M.D., 6070 Orleans Ave., New Orleans, Louisiana, age 26, married, Louisiana State University, 1956, no military obligations, available now.

Thomas S. Whitecloud, M.D., 858 Market Street, Pascagoula, Mississippi, age 45, married, Tulane, 1943, veteran, has interest in teaching, availability date depends on situation.

Internal Medicine

Richard I. Hochman, M.D., 37, Badger Road, Annapolis, Maryland, 31, married, New York University, 1952, available October 1, 1960.

Albert D. Roberts, Jr., M.D., 4333 Colgate, Dallas, Texas, 29, married, Southwestern Medical School, Veteran, available July 1959.

Van B. Saye, Jr., M.D., 1230 Brockenbraugh Court, Metairie, Louisiana, age 28, married, Medical College of Georgia, 1954, Air Force Reserve, available July 1, 1960.

Locum Tenens

Harold W. Calhoon, M.D., Wesley Hospital, Oklahoma City. One year residency in Internal Medicine. Available July 1 to September 15th, 1960.

Arnold Giesbrecht, M.D., Hallock, Minnesota, age 34, married, graduate Winnipeg, Manitoba, 1957, prefers suburban or locality close to cities.

James D. Green, M.D., second year resident in Internal Medicine at St. John's Tulsa, desires one year of Internal Medicine practice before taking third year of training. Prefers clinic in city of 50,000 or greater population.

Russell M. Preston, M.D., 476 San Juan, Oak Harbor, Washington, desires six month's work in General Practice between time of separation from military service to beginning of residency training, January-July, 1960.

Obstetrics and Gynecology

Lynn W. Abshere, M.D., 708 N.E. 14th, Oklahoma City, age 31, married, University of Oklahoma School of Medicine, 1956, American College of OB-GYN, no military obligations, available July 1, 1960.

Gerald R. Keilson, M.D., Medical Arts Building, Dallas, Texas, age 31, married, University of Texas, 1953, board qualified, veteran, available in July 1960.

Milton Gardner Mutch, Jr., M.D., 423 Mills Avenue, Fargo, North Dakota, age 31, married, University of Minnesota, 1955, board eligible upon completion of fellowship, veteran, available July 1, 1959.

David H. Holmes, M.D., 1017 Grovena Drive, St. Louis, Missouri, 37, married, Washington University, St. Louis, Veteran, available July 1, 1960.

Nejdat Mulla, M.D., 1110 Belmont Avenue, Youngstown, Ohio, age 36, married, University of Geneva, Switzerland, 1952, American College of OB-GYN, not eligible military service, available July 1, 1960.

Harold G. Ray, M.D., 212 Darien Place, Box 503, Balboa Heights, Canal Zone, age 28, married, University Arkansas School of Medicine, 1955, now in active reserve, available July 1, 1960.

Alvon C. Winegar, M.D., 1940 Michigan, Benton Harbor, Michigan, age 41, married, Wayne University, 1942, no military obligation, available early 1960.

Pediatrics

H. M. McClintock, M.D., 5712 St. John St., Kansas City, Missouri, 29, married, Baylor University, 1955, veteran, available December 1960.

Surgery

(Name on Request) 32 years old, married, Tulane, 1952, veteran, board eligible.

Johnson P. Graves, M.D., Box 142, Pulaski Heights Station, Little Rock, Arkansas, age 36, married, Arkansas School of Medicine, 1950, board eligible, no military obligations, available Fall 1959.

Olin O. Williams, Jr., M.D., 3768 Alma Drive, Memphis, Tennessee, 29, married, University of Tennessee, veteran, available January 1962.

Urology

Charles Lee Reynolds, Jr., M.D., 5012 Rockport Drive, Dallas, Texas, age 32, Southwestern Medical College, Dallas, 1949, board eligible, married, no military obligations, available July 15, 1960.

Alex Grossman, M.D., V.A. Center, Temple, Texas, 42, married, University of Texas, 1951, board certified, veteran, available now.

Herbert Sohn, M.D., 2010 Cliffview Road, Cleveland, Ohio, 32, married, Chicago Medical School, 1955, veteran, available July 1960.

MISCELLANEOUS ADVERTISEMENTS

FOR SALE: Autoclave, Castle, electric. Originally purchased for $1866.75 in 1956. Contact Walt Allen, 116 North Fourth Street, Chicaksha, Oklahoma.

BARGAINS—in medical equipment, new and used. Largest stock of good used medical devices in the Southwest. Reconditioned and guaranteed. We buy, sell, trade, rent, repair. Examining and operating tables beautifully refinished, rechromed, reupholstered. Tell us about your equipment problems. TeX-RaY Co., opposite St. Paul's Hospital, 3305 Bryan Street, Dallas, Texas.

FOR SALE: $40,000 per year General Practice. 14 room completely equipped clinic. County seat town of 4,000 with new 40 bed hospital. $5,000 will handle. Write Key J, The Journal, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

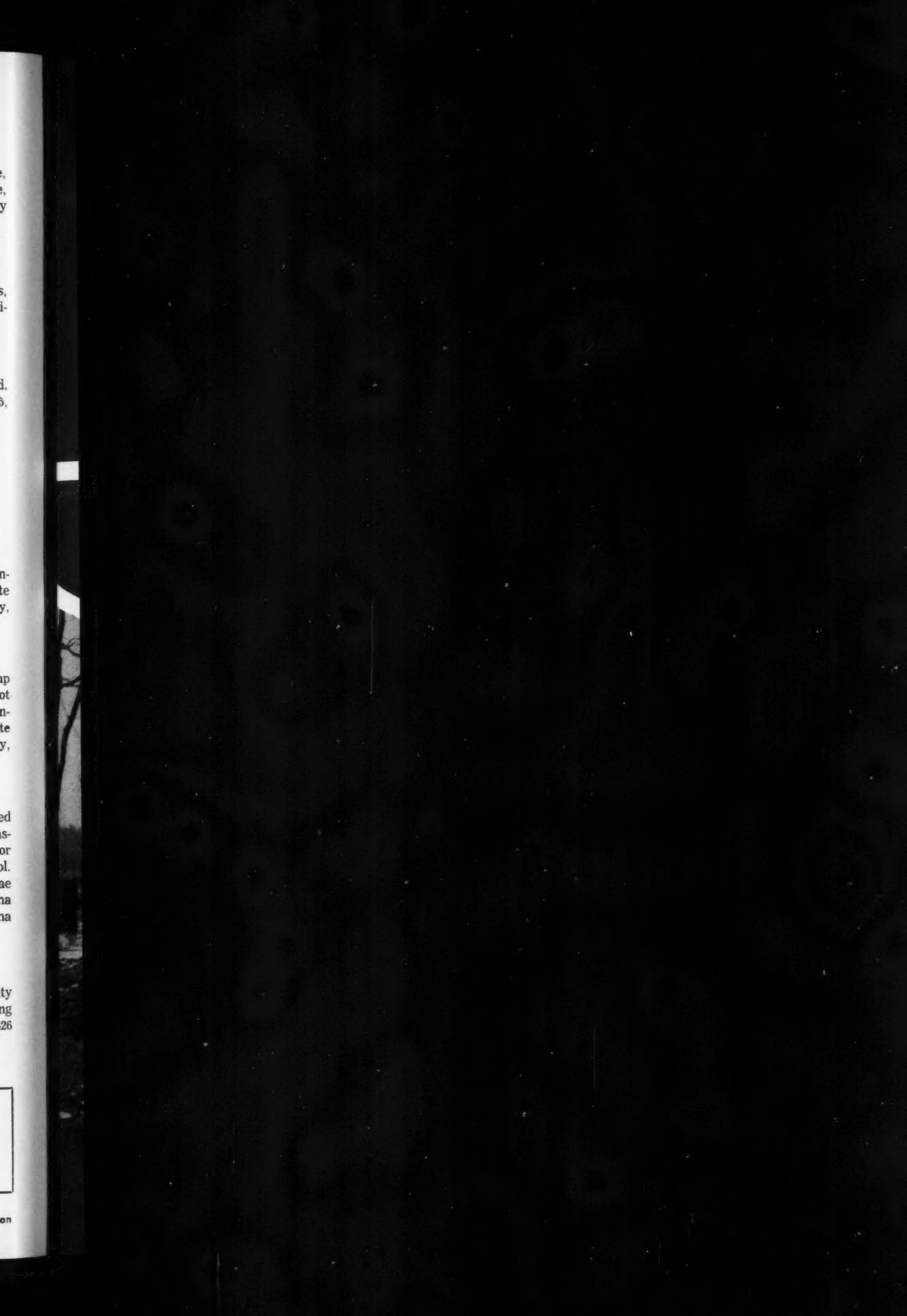
AVAILABLE: Junior Residency, 6 months, Obstetrics, beginning at once at University Hospital, Oklahoma City. Apply Obstetrical Department.

OFFICE SPACE for rent, modern building, 528 N.W. 12th, Oklahoma City. Complete maintenance, air conditioning, free parking space for patients. CE 6-1631.

WANTED: Internist to join old established group in town of 10,000 population in West Texas. Need not be Board certified but with adequate residency training. Write Key A, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

WANTED: Surgeon to join old established group in town of 10,000 population in West Texas. Need not be Board certified but with adequate residency training. Write Key A, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

INTERNIST, Board eligible, 38, family, experienced clinical research, teaching; chief interests cardiovascular, arthritic, geriatric diseases. Prefer Midwest or Southwest individual, small group near medical school. Licensed in Oklahoma. References, curriculum vitae available. Write Key B, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

WANTED: General Practitioner with some ability to do surgery. Primarily industrial practice. Beginning salary $900.00. Contact C. J. Paternostro, M.D., 426 Medical Arts Building, Dallas, Texas.

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